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ABSTRACT

This instructor's guide provides a description of the Johns Hopkins Substance Abuse Curriculum, detailed educational models and other aids for conducting substance abuse teaching activities. The guide is in six sections with Section 1 as a brief introduction and list of 20 references. Section 2 sketches the Johns Hopkins Pediatric Substance Abuse Curriculum by listing knowledge and attitudinal objectives organized under 5 curriculum goals. Section 3, Developing the Program at Your Institution, discusses such topics as needs assessment, goals, instructional plan, choosing teaching methods, evaluations, and recommendations. Section 4 addresses six different teaching strategies. Section 5 contains five substance abuse education modules: (1) Substance Abuse Overview; (2) Current Drugs of Abuse; (3) Substance Abuse Interviewing; (4) Assessment and Evaluation of Adolescent Substance Abuse; (5) Adolescent Substance Abuse Treatment. Each module contains a format, session guidelines, objectives, related curriculum goal(s), synopsis, instructor's resources, session outline, instructor's materials, masters of learner's handouts, equipment list and suggested preparation activities. A final section, Substance Abuse Resources, lists alcohol and other drug abuse resource organizations (including address, telephone number and indication of what type of materials may be available), and audio-visual materials (with a description of each and suggestion for use). (JB)

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ED331392

MODEL PROGRAM AND CURRICULUM IN ALCOHOL AND OTHER DRUG ABUSE FOR PEDIATRIC MEDICAL STUDENTS, RESIDENTS, AND FACULTY

INSTRUCTOR'S GUIDE

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FOREWORD

This project represents another step toward improving substance abuse teaching. It builds upon the work begun in an earlier NIAAA/NIDA project of the Ambulatory Pediatric Association (APA). This initial project (The Identification and Assessment of Alcohol and Drug Medical Education Products/Approaches in Pediatrics) consisted of two major components: assessment of substance abuse teaching in pediatric training programs in the United States, and the development of pediatric-specific minimal knowledge and skills statements for medical students, residents and practicing physicians in pediatrics. These statements are documented in Pediatric Minimal Knowledge and Skills: The First Step in Developing a Curriculum in Alcohol and Other Drugs for Pediatricians.

Development of the competency statements and assessment of the current state-of-the-art of pediatric substance abuse teaching did, indeed, represent the first step toward an effective substance abuse curriculum, in that, the necessary ground work had been laid to develop a competency based curriculum in substance abuse. Coincident with the APA's activities, similar projects were being implemented by organizations in the areas of internal medicine, psychiatry and family medicine. In addition to specialty-specific minimal knowledge and skills statements, core groups from each organization joined in a collaborative project to develop competency statements generic to all medical students, residents, and physicians across the four disciplines. Hence, in addition to laying the groundwork for curriculum development, these projects helped set the right tone — concern for and commitment to improved substance abuse instruction within all four primary care specialties.

Data from the APA's assessment of substance abuse education in pediatric training programs documented the state-of-the-art of education in this area and provided a rationale for addressing improvement. While a few training programs adequately and effectively addressed substance abuse issues as part of pediatric education, the majority of programs did not. The majority of residency programs surveyed offered neither required (60%) nor elective (64%) instruction in substance abuse. Of programs which offered elective instruction, resident participation was less than 20%. At the medical school level, 44% of programs offered required instruction and only 27% offered elective educational experiences in substance abuse. The major impediments identified at all levels of training (medical student, resident, and continuing education) were lack of curriculum time and lack of a qualified staff person. Among all respondents there was an overwhelming endorsement for improving the obvious deficiencies in substance abuse education. More succinctly, it was evident that few training programs systematically addressed substance abuse training.

In summary, the initial steps of curriculum development had begun. A needs assessment for improving substance abuse education was complete and the groundwork for curriculum goals and objectives had been developed, namely the minimal knowledge and skills competency statements. The stage had been set for the next steps: the development, implementation and evaluation of a pediatric specific substance abuse curriculum.

HOW TO USE THIS MANUAL

The purpose of this Instructor's Manual is to assist individuals interested in conducting alcohol and other drug teaching sessions with pediatric medical students, residents, and/or faculty. The content of it is based on our work with medical students, residents, and faculty within The Johns Hopkins University School of Medicine. A more detailed description of our work with these specific groups is documented in Final Report - Specialty Specific Model: To Develop, Implement, and Evaluate a Model Program and Curriculum in Alcohol and Other Drug Abuse for Pediatric Medical Students, Residents, and Faculty, Contract No: 261-86-0009, available from the National Clearinghouse for Alcohol and Drug Information. The final report details information about our curriculum development, implementation, and evaluation processes and activities as they occurred at Johns Hopkins.

Material presented in this instructor's manual is purposely broader in scope. The manual does not propose one best way to develop or conduct substance abuse teaching activities. Instead, using the experience gained from implementation and evaluation at one site, we offer suggestions for developing and improving substance abuse teaching activities at your institution. Therefore, material in this document is presented in such a way as to be flexible enough to meet your needs. A suggested approach to using this manual is offered below:

1. Prior to Planning a Teaching Event, Read Sections I, II, III, IV, and VI

   The Instructor's Manual contains six major sections:

   - Introduction
   - The Johns Hopkins Pediatric Substance Abuse Curriculum

- Developing the Program at Your Institution
- Teaching Strategies
- Substance Abuse Education Modules
- Substance Abuse Educational Resources

The first section summarizes our work in developing a pediatric substance abuse curriculum based on the minimal knowledge and skills statements produced for NIAAA/NIDA (Contract No. 281-85-0014). The second section contains our proposed substance abuse curriculum which encompasses a range of specific knowledge and skill statements. The third section, which generally addresses issues of program and curriculum development, identifies how the instructional program and curriculum can be adapted to your environment and the specific needs of your learners. Included in this section are the issues of curriculum development, implementation, and evaluation. The fourth component identifies a number of different teaching strategies. More importantly, the strengths and weaknesses of each methodology are highlighted. Section five contains specific substance abuse education modules, offering explicit examples and recommendations for such teaching. Each teaching session presented within was tested on various medical audiences (medical students, residents, and/or faculty) within the Johns Hopkins Department of Pediatrics over the course of two years. This section is specifically targeted to those who will be designing or teaching substance abuse educational activities. Finally, identified in section six are educational resources that provide materials or resources to assist you in conducting alcohol and other drug teaching sessions.

2. <u>Select a Substance Abuse Module Appropriate to Your Learner's Needs</u>

Read the modules in Section V. Choose one appropriate for your needs; as you read make notes which you think will specialize the module for use in your institution. After selecting your target audience, consider their special needs.

3. Implement Session Guidelines

Determine available time slots for the session in your target group's schedule. Arrange for the required physical space. Compile and copy the required materials (slide projector, handouts, evaluation form, etc). Request or design publicity for the session. Register and confirm the desired number of participants.

4. Prepare for the Session

You can never spend too much time preparing yourself for a teaching session. Review materials identified in "Instructor's Resources" and study the "Suggested Preparation Activities." Finally, consider your target group and try to anticipate how they will respond to the material you will present. If necessary, contact a resource center (listed in section six) for more information on a particular topic.

5. Conduct the Session

Follow the "Session Outline" in conducting the session.

6. Debrief After the Session

After the session is completed, elicit feedback from participants and/or other facilitators. What were the high points? What could have been handled differently? How did the audience respond to the material? Could it have

been presented in a more effective manner? Document the results of the session as well as the notes from debriefing.

7. Revise the Material or Teaching Methodology

Incorporate changes indicated by your evaluation the next time you conduct the module. If you conduct a different module, consider if any of your suggestions are applicable to it.

8. Update Content Material

Presenting the most accurate and up-to-date material is critical to the success of your teaching activities. Data about alcoholism and other drug topics are constantly emerging, changing, and expanding. To assist you in the process of maintaining updated material, a number of organizations and references are highlighted in this manual.

SECTION I: INTRODUCTION

Statement of the Problem

The use of alcohol and other drugs in American society continues to be prevalent in our society. Consider the following facts:

- The total costs resulting from alcohol abuse, other drug abuse, and mental disorders in 1983 was $218 billion (1).
- It is estimated that approximately one in every 10 adult ambulatory patients has a substance abuse problem (2).
- One in every eight children is the child of an alcoholic (3). These children face unique problems which result from their experience of growing up in an alcoholic family. Consequences include school problems, emotional disturbances affecting social and family relationships, and health problems (4).

Children are also experiencing problems as a result of personal use of drugs and alcohol. The use, misuse and abuse of substances among children and adolescents has become increasingly common in today's society. Since 1975, the National Institute on Drug Abuse has sponsored an annual nationwide survey of approximately 17,000 high school seniors on the use of alcohol, tobacco and other drugs (5). Some results of that study are below:

- In 1986, 51% of seniors in this survey reported using marijuana at some point in their lifetime, with 39% reporting some use in the past year and 23% reporting some use in the past month.
- Four percent of seniors reported actively smoking marijuana on a daily basis.
- Nearly all seniors (93%) reported trying alcohol, and the great majority (87%) reported using it during the past year.

This use is not without consequences: young people aged 15-24 comprise the only group to experience an increase in mortality rate over the past decade, with the sharpest increase noted for 15-19 years old.

Adolescents' use of alcohol and other drugs has changed over the years.

There exists a propensity toward earlier initiation of drug use in today's society. The Alcohol Epidemiologic Data Systems of NIAAA reports the average age for initiation of alcohol or other drug use to be 14 years old. There is also an inclination among today's youth to simultaneously use more than one drug. Among current users in a recent statewide survey of adolescents, the average young adolescent (8th grader) used 3.4 drugs (7). This, too, is disturbing since recent data suggest that high levels of poly-drug use as a teenager are associated with drug-related problems later in life (8).

Despite the emergence of alcohol and other drug use as a major health problem over the past 20 years and the known problems (medical and otherwise) that stem from it, little time in medical education is spent providing physicians with the knowledge and skills needed to effectively address this problem (9). Given their involvement with parents and children, pediatricians have a distinct opportunity to establish a primary role in prevention, intervention and treatment of substance abuse (10-12). However, it is only through familiarity with this disorder, just as with other chronic disease processes, that primary care physicians will be able to adopt a more prominent role in this area.

Historically, the teaching of alcohol and other drug abuse in medical schools has been neglected. Although several surveys of medical school curricula have indicated an improvement in addressing this area over the last decade, a large number of schools still teach very little about this subject (13). In addition, while alcohol and other drug abuse education has been inadequate overall, existing data show that there has been very little, if any, pediatric teaching time devoted to this critical area (14), despite its major impact on children and youth (15,16).

Role of the Pediatrician

Several individuals and committees have attempted to delineate the role of the pediatrician vis á vis alcohol and other drug use (17-20). Most agree an appropriate role for pediatricians should include substance abuse screening, interviewing, and treatment, as well as, substance abuse education and prevention with both patients and parents. Unfortunately, few, if any, address the very real questions of how to get pediatricians to accept their role and how to equip them to fulfill it.

Hopefully, our experiences with this issue have lead to some insight that we will share with you in this manual. Most importantly, we believe for one to truly embrace and implement a role, it must be one that is adopted as a result of participating in planned learning activities and examining personal attitudes — not because the role was mandated for him/her. This does not mean that educators are powerless; quite the contrary. Through the careful design and implementation of appropriate instructional/learning activities, educators can help individuals adopt a more prominent role for themselves and embrace a broader role for pediatricians in general.

Philosophy of the Curriculum

The PSAC curriculum is designed to address substance abuse education at the undergraduate, graduate, and faculty levels within a department of pediatrics. It is our assumption that individuals bring with them a specific set of knowledge, attitudes and practice behaviors which have been shaped by their past experiences. We also believe, based on data from our assessment of pediatric substance abuse teaching, that, regardless of the level of training, most pediatricians suffer from the same relative paucity of specific knowledge and skills related to substance abuse and share the same need for a basic understanding of the manner and extent to which substance abuse related issues interface with a pediatric population. Therefore, our

abuse related issues interface with a pediatric population. Therefore, our educational program includes individuals at all levels of training in order to have the desired reinforcing and sustaining effect. The effect and impact of positive role models is an important component of the educational program.

REFERENCES

1. Kamerow DB, Pincus HA, MacDonald DI. Alcohol abuse, other drug abuse and mental disorders in medical practice; prevalence, costs, recognition and treatment. JAMA 1986; 255 (15):2054-2057.

2. Whitfield CL, Davis JE, Barker RL. Alcoholism (Chapter 21) in Principles of ambulatory medicine. Barker, Burton, Zieve (ed). Williams and Wilkens (2nd ed, 1986)

3. MacDonald DI. Patterns of alcohol and drug use among adolescents. Ped Clinics of N America 1987; 34(2): 275-288.

4. US Department of Health and Human Services. A growing concern: how to provide services to children from alcoholic families. Public Health Service. Alcohol, Drug Abuse and Mental Health Administration. DHHS Publ. No. (ADM) 85-1257, 1985.

5. Johnston LD, O'Malley PM, Bachman JG. National trends in drug use and related factors among american high school students and young adults, 1975-1986. National Institute on Drug Abuse. DHHS Publ. No. (ADM) 87-1535, 1987.

6. US Department of Health and Human Services. Sixth special report to the US congress on alcohol and health. Alcohol, Drug Abuse and Mental Health Administration, NIAAA. DHHS Publ. No. (ADM) 87-1519, 1987.

7. Maryland Department of Health and Mental Hygiene-Drug Abuse Administration. 1984 survey of drug abuse among Maryland adolescents - general report. MDHMH 1985.

8. Newcomb MD. Stabilization of drug use patterns from adolescence to young adulthood. Paper presented at the American Public Health Association Annual Meeting, Boston, November 1988.

9. Kinney J, Price TRP, Bergen BJ. Impediments to alcohol education. J of Studies on Alcohol. 1984; 45(5):453-459.

10. DuPont RL. Prevention of adolescent chemical dependency. Ped Clinics of N America 1987; 34(2):495-505.

11. AAP Committee on Adolescence. The role of the pediatrician in substance abuse counseling. Pediatrics 1983; 72:251.

12. Schwartz RH, Cohen PR, Bair G. Identifying and coping with a drug-using adolescent: Some guidelines for pediatricians and parents. Pediatrics in Review 1985; 7:133-139.

13. Lewis DC, Niven RG, Czechowicz D, Trumble JG. A review of medical education in alcohol and other drug abuse. JAMA 1987; 257:2945-2948.

14. Adger H, McDonald EM, DeAngelis C. The identification and assessment of alcohol and drug medical education products/approaches in pediatrics, final report. National Institute on Alcohol Abuse and Alcoholism and National Institute on Drug Abuse (ADM) Contract No. 281-85-0014, 1986.

15. MacDonald DI, Blume SB. Children of alcoholics. AJDC 1986; 140:750-754.

16. Sixth Annual Report to the U.S. Congress on Alcohol and Health. U.S. Department of Health and Human Services Publication No. (ADM) 87-1519, 1987.

17. Parcel GS. The pediatrician's role in drug education. Ped in Review 1983; 4 (5): 144-149.

18. Committee on Adolescence. The role of the pediatrician in substance abuse counseling. Pediatrics 1983; 72(2): 251-252.

19. DuPont RL. Teenage drug use: opportunities for the pediatrician. J of Pediatrics 1983; 102(6): 1003-1007.

20. American Academy of Pediatrics Committee on Adolescence. Alcohol use and abuse: a pediatric concern. Pediatrics 1987; 79(3): 450-452.

CURRICULUM GOAL 1: INCREASE AWARENESS OF GENERAL CONCEPTS OF SUBSTANCE ABUSE

KNOWLEDGE OBJECTIVES	CONTENT AREAS
THE LEARNER WILL BE ABLE TO:	
1) Define commonly used terms	Experimentation Abuse Dependence Withdrawal Co-dependence
2) Define the DSM III-R diagnostic criteria for substance abuse and dependence and understand their applicability to children and youth	DSM III-R
3) Describe the epidemiology of substance abuse	General population Infants, Children and Adolescents Familial/peer group associations Children of alcoholics
4) List the predisposing risk factors for substance abuse	Environmental influences Dysfunctional families Genetic influences

CURRICULUM GOAL 1 (cont)

KNOWLEDGE OBJECTIVES	CONTENT AREAS
THE LEARNER WILL BE ABLE TO:	
5) Describe the relationship between substance abuse and specific sequelae as they relate to children and youth	Injuries, suicide, homicide Physical/sexual abuse Neonatal substance abuse related problems
6) Describe the progressive stages of substance abuse	Experimentation Misuse Abuse Dependence
7) Be familiar with individual characteristics and family dynamics related to substance abuse	Individual Roles -enabler -scapegoat -hero -mascot Family Behavior/Dynamics

ATTITUDINAL OBJECTIVES
THE LEARNER WILL BE ABLE TO:
1) Challenge personal beliefs and prejudices related to substance abuse including stereotypes, universality of the problem, etiology and progression
2) Recognize substance abuse as a disease
3) Recognize substance abuse as an important health problem in children, adolescents and adults

CURRICULUM GOAL 2: PROMOTE FAMILIARITY WITH COMMON DRUGS OF ABUSE

KNOWLEDGE OBJECTIVES	CONTENT AREAS
THE LEARNER WILL BE ABLE TO:	
1) Identify common drugs of abuse	Alcohol Stimulants Cannabinoids Depressants Inhalants Hallucinogens Nicotine Cocaine Opioids
2) For each of the classes of commonly abused drugs outline:	
a) the basic pharmacology	Common behavioral and physiological effects and side effects
b) patterns of use	
c) acute and chronic effects	Clinical presentation of acute intoxication and its adverse reactions Management plan for acute and chronic adverse reactions
d) withdrawal characteristics	Basic characteristics of dependence, addiction and withdrawal

CURRICULUM GOAL 3: INCREASE RECOGNITION AND DIAGNOSIS OF SUBSTANCE ABUSE AND ITS RELATED SEQUELAE

KNOWLEDGE OBJECTIVES	CONTENT AREAS
THE LEARNER WILL BE ABLE TO:	
1) List several currently available screening instruments and describe their potential application in a pediatric setting	C.A.G.E. M.A.S.T. plus addendum A.A.I.S. Use/Concern Perceived Benefits of Drinking Scale
2) Identify common signs or symptoms suggestive of substance abuse	Behavioral change School performance and attendance Delinquent behavior Familial discord Social and peer group interaction Physical signs
3) Identify patient and physician factors which interfere with substance abuse recognition	Characteristics of substance abuse/dependence Denial by patient, physician, family Inappropriate inquiry or history taking

CURRICULUM GOAL 3: (continued)

KNOWLEDGE OBJECTIVES	CONTENT AREAS
THE LEARNER WILL BE ABLE TO:	
4) List several aids to assist in the organization and inquiry of pertinent information	P.A.C.E.S. (peers, alcohol, cigarettes, education, sex) H.E.A.D.S (home, education, activities, drugs, sex) Four F's (friends, future, fertility and family)
5) Identify specific signs and symptoms of newborns related to maternal substance abuse	Fetal Alcohol Syndrome Neonatal Drug Withdrawal Acquired HIV Infection

SKILL OBJECTIVES	CONTENT AREAS
THE LEARNER WILL BE ABLE TO:	
1) elicit substance use/abuse information from a patient or family	Skills Checklist for Substance Abuse Interview
2) demonstrate interview techniques which enhance recognition of substance abuse	Skills Checklist for Substance Abuse Interview
3) make use of data gathered from patient/family history and physical exam to establish a diagnosis or determine the need for further assessment	Substance Abuse Diagnosis
4) identify and make use of consultation where necessary to establish a diagnosis	Substance Abuse Diagnosis

CURRICULUM GOAL 3: (continued)

ATTITUDINAL OBJECTIVES

THE LEARNER WILL BE ABLE TO:

1) value the importance of skills necessary to effectively screen for and recognize substance abuse

CURRICULUM GOAL 4: PROVIDE BASIC SKILLS TO EFFECTIVELY INTERVENE AND ENGAGE THE PATIENT AND FAMILY INTO TREATMENT

KNOWLEDGE OBJECTIVES	CONTENT AREAS
THE LEARNER WILL BE ABLE TO:	
1) discuss the role of the pediatrician	Diagnosis Treatment Prevention
2) discuss individual roles and family dynamics as related to chemical dependency mechanisms in the resistance to treatment	Individual Roles -hero -enabler -scapegoat -mascot Family Systems/Dynamics
3) discuss the impact of defense mechanisms (of patient, family, or physician) in the resistance to treatment	Defense Mechanisms -denial -avoidance -minimizing
4) identify treatment options appropriate for the various stages of substance abuse	Treatment approaches Treatment matching Basic philosophy of treatment approach
5) identify specific resources within the community	Treatment Programs Resource Catalog

CURRICULUM GOAL 4: (continued)

SKILL OBJECTIVES	CONTENT AREAS
THE LEARNER WILL BE ABLE TO:	
1) develop communication skills that foster open discussion of alcohol and other drug use	Primary Prevention Anticipatory Guidance Interview Skills
2) develop intervention skills that obviate resistant strategies of the patient and family (ie, caring, empathy)	Intervention Process
3) make use of community resources to effect patient treatment	Resource compendium

ATTITUDINAL OBJECTIVES
THE LEARNER WILL BE ABLE TO:
1) recognize the importance and benefit of treatment
2) recognize the importance of the role of the pediatrician in diagnosis and treatment
3) recognize the importance of providing on-going support and medical follow-up to a patient and family in treatment

CURRICULUM GOAL 5: PROMOTE AWARENESS OF THE PEDIATRICIAN'S ROLE IN PREVENTION

KNOWLEDGE OBJECTIVES	CONTENT AREAS
THE LEARNER WILL BE ABLE TO:	
1) discuss the importance of primary prevention	Prevention strategies for youth
2) identify appropriate opportunities to discuss substance use with patients and family	Anticipatory guidance
3) utilize knowledge of age appropriate behavior to identify early warning signs of substance use/misuse	Progressive stages of use Developmental/behavioral progression of adolescence Early warning signs

SKILL OBJECTIVES	CONTENT AREAS
THE LEARNER WILL BE ABLE TO:	
1) educate the patient and family about substance use	
2) incorporate discussion of substance abuse issues into anticipatory guidance	

ATTITUDINAL OBJECTIVES

THE LEARNER WILL BE ABLE TO:

1) value the role of the pediatrician in substance abuse prevention

2) recognize the importance of general health promotion regarding substance abuse

SECTION III: DEVELOPING THE PROGRAM AT YOUR INSTITUTION

A. Program and Curriculum Development

Creating any educational program is a complex activity. This activity can be more manageable if you adopt/create a conceptual model which can serve several functions. Initially, choosing or developing a model forces you to think about and begin to plan your program. Secondly, the model allows for division of a complex task into smaller component parts. Finally, the model can be used as a "roadmap", providing both guidance and direction for moving forward as well as chronicling the previous steps. There is no one best model for curriculum development; the choice of the model should be based on your needs. Included in Appendix A is an example of a generic curriculum development model comprised of six discrete steps: assessment of needs, clarification of goals, development of the curriculum, devising an instructional plan, assessment of outcomes, and evaluation. Regardless of your desire to implement an entire program or a one-time teaching session, each of these steps should be considered. Each component of the program development process is addressed below.

1. Needs Assessment

Whether developing a new unit of instruction, revising a currently existing program or creating a new curriculum, you should become familiar with your environment. Simply put, environment includes any entity that might impact upon your work. Factors that may be part of an assessment include:

Target audience or prospective learners: to identify current levels of knowledge, attitudes and behaviors; to determine previous types of training received; to identify special areas of interest among group(s)

Time: to determine the amount of time available for planning,

implementing, evaluating the activity; to determine the most effective time period for instruction (eg. 1 hour vs. 4 hour sessions)

Resources: to identify materials to aid in the planning, implementing and evaluating of teaching activities; to identify financial resources designated for substance abuse teaching; to identify individuals who can facilitate planning, implementing, and evaluation teaching activities

Relevant Data/Materials: to identify the state-of-the-art in substance abuse teaching; to identify controversies in the field that may impede curriculum development or acceptance; to identify relevant data and materials

Facilities: to identify treatment facilities in the area that may be used as learning experiences for target audiences; to identify resource organizations for substance abuse information

Philosophy of organization: to identify the congruence or divergence of organizational goals versus the proposed goals of the curriculum

Substance abuse patients: to identify the prevalence of alcoholism and other drug abuse among patients/families that interact with your target group(s)

Current curriculum: to identify in the current curriculum areas where substance abuse education should, could, or does occur; to identify gaps or overlaps in substance abuse content currently in the curriculum; to identify typical teaching methodologies used at each level of physician training

During assessment of your environment, it is important to remember not to examine only those factors/resources that might be of benefit to you. Equally important is the assessment of potential barriers. By assessing these factors during the planning and development stage, a strategy of program implementation can be developed cognizant of these obstacles. Often, by bringing potential opponents into a program or activity during its planning stages, problems can be identified and resolved.

Because needs assessment serves as the foundation of program development, you should be familiar with and confident about the methods used to collect data. This does not necessarily mean that you are limited to the more traditional assessment procedures (eg., interviews, surveys, record

reviews); but, it does forworn you to be prepared to defend the appropriateness and validity of your assessment approach.

2. Goals

Goals provide a rationale for selection of objectives and content. Identification of the major goals of the curriculum or teaching activity can be done simply by asking yourself what do you want your participants to be able to do. As such they determine the scope and define the boundaries of your activity or curriculum. Furthermore, specific content is elucidated and organized around the goals of the activity. Finally, curriculum goals have a role in the evaluation of the program. They begin to guide the development of the evaluation plan since, upon their delineation, the desired outcomes have been identified.

3. Curriculum

Once preliminary assessment data are collected and goals are formulated, the next step is to focus on the development of the actual curriculum. Curriculum development, the selection and organization of <u>what</u> is to be taught, is directly controlled by the specific learner objectives. These learner objectives, which stem from the curriculum goals, identify specifically the knowledge, skills and attitudes to be achieved by the learner. The most effective objectives are written in measurable terms and identify the degree to which the task must be mastered by the learner in order to indicate success.

Once learner objectives are written, the specific content can be delineated. Content is defined as that knowledge-based, skill-related, or attitudinal-oriented information that is presented to the learner in order to meet a specific objective. The selection of content is important to a curriculum's success. Criteria for content selection include its

significance, validity, utility, effectiveness, feasibility and appropriateness.

4. Instructional Plan

The instructional plan differs from the curriculum in that the plan "operationalizes" the curriculum. Instructional planning is an iterative process; a decision about one component affects the others. Four components comprise an instructional plan. Although these components are addressed simultaneously during instructional planning, here each component is addressed separately for the purpose of clarity.

a. Choosing teaching methods

Choosing the most appropriate teaching strategy is a critical component of a teaching activity's success. The importance of matching teaching methodologies with intended learning outcomes cannot be overstated. Even the most organized curriculum can break down if methods of instruction are inappropriate or inconsistent with the intended learning outcomes. A curriculum addresses a number of different kinds of learning, for example, knowledge attainment, skill attainment and attitudinal issues. These distinct types of learning require different teaching methodologies. For these reasons, it is important for instructors to have a strong working knowledge of the different types of teaching methodologies, and to understand which teaching methods are better suited to each type of learning. For a review of several teaching strategies and their relative strengths and weaknesses see Section IV.

b. Identifying target audiences (adapting to audience needs)

Groups, just as individuals, have different needs. No learning experience is going to fulfill all the needs of all its participants. The best we can do, as program planners, is learn to assess a group's needs and

revise the curriculum and learning activity accordingly. For example, a substance abuse training session with second year medical students is different than that with faculty. Moreover, a session with clinically active faculty is going to vary from that for faculty who conduct only research. What is it about these groups that makes them different? Listed below are a few factors that make them different.

- clinical experience
- age
- attitudes and values
- motivation for learning
- current fund of knowledge

The more familiar you are with the group participating in the training, the more you can tailor the sessions and curriculum to meet their needs.

c. Identifying location and time

Sometimes, these factors are already determined for you. However, when you are open to make this decision, consider it carefully. There is no one location that is the best for all situations; instead, it is a matter of appropriately meeting the needs of the group. Identifying a location for a session includes a variety of decisions. Questions that will help guide your thinking are listed below:

- Where in the overall curriculum is your substance abuse curriculum? Are the goals of your curriculum congruent with the overall curriculum?
- How do your teaching activities relate to previous or concurrent teaching sessions by others? Will they complement other teaching activities? Will this affect the content's acceptance by learners or by other

instructors?

- How much time is needed to conduct your sessions? Is this an optimal amount of time to affect the needed change?
- Where in the course of the day do your teaching sessions occur? Is this considered an acceptable time by potential participants?
- Given your location(s) and time(s), are your teaching sessions available to potential participants?

d. Determining evaluation methods/procedures

Evaluation methods should be dictated by, among other things, the type of competency to be attained. Certain evaluation methods, such as practice pattern reviews and direct observation, are best suited to skill-oriented competencies while others (written or verbal tests) are the preferred method for cognitive competencies.

5. Learning outcomes

Intended learning outcomes represent the desired effect of the curriculum on its participants. Assessment of reaching these outcomes is addressed more completely in the next section. It is important to remember that teaching activities or a training program can also have unintended effects on its participants and its environments. These unplanned outcomes can be either positive or negative in nature; this too is addressed more specifically in the next section. What is important to remember about learning outcomes, regardless of status, is to document all changes that occur during your training program. This documentation will allow you to examine the situation more closely and come to conclusions on why the unintended outcomes occurred.

6. Evaluation

Evaluation should be viewed as an integral part of program development and implementation. Moreover, there should be an interdependence between curriculum and evaluation methods. That is, curriculum characteristics will dictate the preferred method of evaluation (e.g., knowledge measured by questionnaire, practice measured by observation), and evaluation findings will influence subsequent curriculum design.

Evaluation is defined as the systematic data collection for decision making. The collection of data can be used as a means of determining the success of the learning experiences by measuring the degree of congruence or disparity of the desired outcome with the actual outcome of the program and its educational activities. In a substance abuse educational program, there can be many questions and decisions for which systematic data collection is required. For example:

- How well are students accomplishing the course objectives?
- How effective are the teaching strategies?
- How effective are the instructors?
- Are students participating in the sessions?

The first step in developing an evaluation system is to decide which of these or other questions are so important or have so little available information that a data collection (evaluation) system is required. The second step is to identify who will use the information and in what form they want it. Usually, steps one and two occur concurrently. If the evaluation is to really be used, it is very important to have actual people (not nebulous committees or funding agencies) with identified questions committed to using the evaluation data.

Thirdly, the data are collected. Two major types of evaluation are of

import for program development: process evaluation and outcome evaluation. Process evaluation involves assessing all key factors as a program unfolds. These key factors might include: people, such as staff, patients, program participants and opponents; events, such as the number of teaching sessions implemented; and problems, such as inaccessibility to a target group and lack of participation in training sessions.

Process evaluation should occur as unobtrusively as possible and does not necessarily require a great deal of resources. Methods of process evaluation include direct observation, utilization reports, and discussions with staff and program participants. The method is not the most important aspect of process evaluation. Instead, it is more important to collect information that will provide you insight into the accessibility and availability of your program to its intended audience, as well as the need for modification. A curriculum could incorporate effective educational components and be a failure because the sessions are inaccessible to the participants. This type of process information will aid you in the decision to revise your current efforts.

Outcome evaluation is designed to document the changes in participants, policies, environments, etc., as a result of program implementation. Certainly, reduced mortality and morbidity due to alcoholism and other drug abuse are the ultimate goals of any substance abuse effort; however, such outcomes are rarely evident within the time frame of a project. Therefore, more immediate goals, such as the curriculum goals, should be used to organize your evaluation efforts. Evaluation methods should be dictated by, among other things the type of competency to be attained. Certain evaluation methods, such as practice pattern reviews and direct observation, are best suited to skill-oriented competencies while others (written or verbal tests)

are the preferred method for cognitive competencies. Numerous data collection strategies exist: survey, observation, chart audit, and knowledge exam, among others.

Finally, it is important to summarize and present the data in a format which will be most useful to the decision maker(s), e.g., formal quantitative reports, verbal reports, summary of findings only.

B. Recommendations

1. Programmatic Recommendations

a. Need for Institutional/Departmental Support

Institutional and departmental support are critical to the successful integration of a substance abuse curriculum into a pre-existing curriculum. Support from department leaders can do a great deal in facilitating the implementation of teaching events, and, if necessary, requiring participation in teaching events from department members. Also departmental support is critical for gaining access to the resources (money, time, people, materials) required to conduct teaching efforts.

b. Need to Initiate Research (be research oriented)

Programs in substance abuse should be research oriented for a number of reasons. The field of alcoholism and other drug abuse are fertile ground for research. Many questions about these areas remain unanswered. In addition, projects that initiate research ideas and proposals are often encouraged by departments because they represent a potential source of income for an institution. One way to ensure the existence of a project is to make it self-sufficient; if no money is required from the department, it will be looked upon more favorably. A strong research orientation by a project is recommended because it attracts junior faculty who see this as an opportunity

to develop professionally in one area that has many unanswered questions. Finally, research is suggested because it provides an objective measure of the contributions that result from a project.

2. Recommendations for Curriculum Development/Implementation/Evaluation

a. Need competency-based approach

The importance of a competency-based approach can not be over-estimated. As was noted throughout this document, competencies are integral in planning and development (since they provide direction and purpose to these activities), implementation (since they provide a focus to the teaching activity), and evaluation (since they serve as the measure by which you can evaluate someone or something).

b. Need learner-centered curriculum

A curriculum that is learner-centered is focused on the needs of its proposed target group. For this reason, it is more likely to be viewed by its participants as a positive experience and as an activity that will be able to provide them with important and effective skills.

c. Emphasize experiential teaching methods

Medical education in general has been slow to incorporate the use of experiential teaching methods into its curriculum, relying for the most part on lectures and reading. However, substance abuse education that uses experiential teaching methods can serve as a model for effectively using such techniques. While a number of different experiential teaching methods exist, all share one similarity--an active learner.

d. Focus on skill development

Our work seems to indicate that a teaching activity that provides its participants with <u>usable</u> knowledge and skills is more likely to be perceived as effective by its participants. Skill development should be emphasized in

a curriculum; but remember, without the necessary knowledge base, skills alone can provide only limited help.

e. Effective use of evaluation

Although evaluation is a critical component to the successful development and implementation of a curriculum, one should use it efficiently. That is, even though evaluation data are important, there may be instances when it is not feasible to collect data. The need for evaluation data should be weighed against the possibility of "turning-off" participants who might feel "over-evaluated".

SECTION IV: TEACHING STRATEGIES

A. Teaching Methodologies

The number of teaching formats or methods that exist is limited only to an instructor's imagination. Some of the more traditional forms of teaching (lecture, reading) represent those that are better suited for low-level cognitive objectives, such as learning factual information. Higher level cognitive abilities (synthesis, analysis, judgement) and affective abilities are best learned via interactive strategies. Whatever format is used, students should be provided frequent feedback and practice opportunities. Most importantly, formats should be selected which fit well within the overall curriculum considering such factors as available time, resources, and student characteristics. In addition, medical educators and curriculum developers must recognize the strengths and weaknesses associated with each teaching methodology as well as the requirement of each learning situation.

1. Lecture

The lecture format has several strong points. Lecturing requires minimal preparation of materials, is not affected by the number of students in a class, and makes economical use of class space. Moreover, the rate at which information is communicated is dictated by the instructor. But, inherent in this teaching strategy may be serious weaknesses as well. A foremost problem with lecturing is that the activity is teacher-centered rather than learner-centered. That is, the instructor does most of the talking while student involvement is virtually non-existent. Student involvement in a lecture can be enhanced through the use of direct and indirect questioning, as well as, the use of visual aids such as a chalkboard, flipchart, or overhead projector.

2. Audio-visual materials

The use of audiovisual aids such as films and videotapes represents another often used teaching format. While many quality films and videos are available, it is important to avoid the temptation to substitute the instructor with a film. Used as a supplement to the teacher, however, audiovisual materials can make the learning experiences more interesting and relevant to the learner. A potential weakness associated with the use of audiovisuals is that the selection of appropriate and effective material may be time consuming and costly.

3. Role play

Roleplaying, the process of simulating events, situations or encounters, is an effective methodology with many advantages. During role playing, the learner is active; the experience is student-centered. The student is given the opportunity to experience a situation in a "safe" setting, exploring the problems inherent in assimilating information and reaching appropriate conclusions. Moreover, role playing allows the students to identify and explore their feelings and attitudes and determine how these affect their behavior. However, for role playing to be an effective learning experience, careful planning is necessary. For example, there may be instances when the role play situation requires only two participants out of a class of 10. The instructor must decide if 4 additional diads should be set up to allow everyone to participate, or if the remaining 8 people could be used to critique the role play. If the later example is chosen, learning for the "critics" is facilitated if an observation guideline or checklist is developed and reviewed with the group.

4. Computer assisted instruction

Computer assisted instruction is another teaching methodology with both

advantages and disadvantages. Although the programs and equipment can be very expensive at the onset, when used for large groups this modality may prove very cost effective. Computerized self-instruction allows the learner to move at his own pace. In addition, the student is immediately evaluated by the computer at each step in the learning process.

5. Clinical teaching

Teaching strategies used within clinical settings differ from those utilized in didactic settings. In the clinical setting, case studies no longer come from textbooks. Instead, patients are the resource of information and learning is achieved through dealing directly or indirectly with the patient. Although a student is only indirectly involved with the patient, the nuances and intricacies of the skill are clearly demonstrated. Similarly, by participating in a clinical course rotation, the student, under supervision, will be responsible for providing care to the patient. In this situation, the student will learn in a setting that most resembles the real work world.

6. Self-help group exposure

A number of different activities are evolving and becoming recognized as important and effective substance abuse teaching methodologies. One such activity is the use of self-help groups. Student participation in self-help groups, such as Alcoholics Anonymous, are particularly effective in addressing attitudinal issues. We have found that debriefing with students after such activities facilitates learning.

SECTION V: SUBSTANCE ABUSE EDUCATION MODULES

A. How The Modules are Organized

Each MODULE is divided into 10 different sections:

TITLE	FORMAT(S)
SESSION GUIDELINES	OBJECTIVES
RELATED CURRICULUM GOAL(S)	SYNOPSIS
INSTRUCTOR'S RESOURCES	SESSION OUTLINE
INSTRUCTOR'S MATERIALS	MASTERS OF LEARNER'S HANDOUTS
EQUIPMENT LIST	SUGGESTED PREPARATION ACTIVITIES

A description of each section's purpose and contents is below.

TITLE

This is the suggested title of the teaching activity.

FORMAT(S)

Format(s) identifies the suggested teaching method(s) to be used to implement the session. For some teaching activities only one format is identified; for others, several are noted. The documented format(s) represent those teaching methodologies that were used during the implementation of the session at Johns Hopkins Hospital. If resources and time are available to use experiential teaching methodologies, do so.

SESSION GUIDELINES

Identified in this section are recommended guidelines concerning the time, prerequisites, space, and number of participants for each teaching session. Time identifies the minimal amount of time required to complete the teaching session. If more time is available, strategize on ways of using it effectively in the teaching. Prerequisites notes those sessions that should be implemented prior to the activity on which you are working. Space recommendations may include subtopics such as size of the room and seating arrangements for maximum learning. The optimal range of participants is also identified in this section. All of these recommendations are based on work with specific audiences and may be applicable to other groups. However, remember to consider any unique features of your setting or participants while you are planning the session.

OBJECTIVES

This section identifies the specific knowledge, attitude or behavior to be acquired by the learner as a result of the session. If these objectives do not meet the needs of the learner, revise the objectives and the session.

RELATED CURRICULUM GOAL(S)

Learner objectives are derived from curriculum goals. Curriculum goals broadly state the intentions of a curriculum. Curriculum goals related to the specific teaching activity in question are identified in this section. As with the objectives, if the goals are not appropriate, revise them to meet the needs of your participants.

SYNOPSIS

A brief description of the teaching session is contained in this section. Included in the description of each session is the rationale or justification for the activity. Highlighted for the instructor is the importance the session, providing criteria for inclusion into the curriculum.

INSTRUCTOR'S RESOURCES

In order to facilitate the instructor's preparation prior to the session, suggested reading materials are identified in this section.

SESSION OUTLINE

The proposed organization of data and concepts to be presented is contained in the Instructor's Outline. In addition, specific recommendations are also noted for the instructor's information. Finally, the handout(s) corresponding to the material being covered are also identified in the Instructor's Outline.

INSTRUCTOR'S MATERIALS

Specific material to be used by the instructor during the session is listed here. Familiarity with these materials is crucial to the success of the teaching activity.

MASTERS OF LEARNER'S HANDOUTS

All materials to be used by participants during the course of the activity are included in this section. The materials are camera ready. Also included are materials that may or may not be referred to specifically during the teaching session; but, they are applicable to the content of the session. These serve as additional resources for the participants. It is often helpful to make copies prior to the session and arrange them in folders for the participants' use during the session.

EQUIPMENT LIST

Equipment and materials needed for each session are listed here. Some sessions require no specific pieces of equipment. Others may suggest the use of certain items. Again, this list is not all-inclusive. It should be used by the instructor as a starting point for documenting and organizing equipment needs.

SUGGESTED PREPARATION ACTIVITIES

A list of proposed preparation activities is included in this section. Many of the same activities are listed for all the modules; however, activities unique to an individual module are also documented. This list is in no way complete and is really to serve as a reminder to the instructor. The list should be adapted to suit particular needs of a session.

B. Individual Modules

SECTION VI: SUBSTANCE ABUSE RESOURCES

A. Alcohol and Other Drug Resource Organizations

Addiction Research Foundation (807) 595-6000
Marketing Services
33 Russell Street
Toronto, Ontario, Canada M5S 2S1

Materials Available: Pamphlets, booklets, posters, A/Vs, curricula, bibliographies

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Al-Anon Family Group Headquarters, Inc. (212) 683-1771
Madison Square Station
Box 182
New York, NY 10159-0182

Materials Available: Pamphlets, books, newsletters, posters

American Academy of Pediatrics (312) 228-5005
141 Northwest Point Road
Elkgrove, IL 60007

Materials Available: Pamphlets, reprints, posters

American College Health Association (301) 963-110
15879 Crabbs Branch Way
Rockville, MD 20855

Materials Available: Pamphlets

American Council for Drug Education (301) 984-5700
6193 Executive Boulevard
Rockville, MD 20852

Materials Available: Catalog, pamphlets, monographs, A/Vs, speakers kit on marijuana

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American Council on Alcohol Problems (515) 276-7752
2908 Patricia Drive
Des Moines, IO 50322

Materials Available: Pamphlets, newsletter

American Educational Materials, Inc. (714) 761-8661
P.O. Box 2613
Anaheim, CA 92804

Materials Available: Cartoon booklets, A/Vs

American Medical Association (312) 645-5000
Department of Health Education
535 North Dearborn Street
Chicago, IL 60610

Materials Available: Pamphlets, professional reports

Audiovisual Library Service (612) 373-3810
University of Minnesota
3300 University Avenue, S.E.
Minneapolis, MN 55414

Materials Available: Audiovisual materials

Center for Science in the Public Interest (202) 332-9110
1501 Sixteenth Street, N.W.
Washington, DC 20036

Materials Available: Books, posters

Center of Alcohol Studies (201) 932-3510
Rutgers University
P.O. Box 969
Piscataway, NJ 08854

Materials Available: Clearinghouse for alcohol information

Do It Now Publications (602) 257-0797
P.O. Box 5115
Phoenix, AZ 85010

Materials Available: Pamphlets, booklets, posters, reprints

Food and Drug Administration (301) 443-6500
Office of Consumer Affairs
5600 Fishers Lane
Rockville, MD 20857

Materials Available: Pamphlets, reprints, A/Vs

Hazelden Educational Services (800) 328-9000
Box 176
Pleasant Valley Road
Center City, MN 55012-0176

Materials Available: Pamphlets, booklets, books, A/Vs

Insurance Information Institute (212) 669-9200
110 William Street
New York, NY 10038

Materials Available: Pamphlets, books, A/Vs

Insurance Institute for Highway Safety (202) 333-0770
Suite 300
Watergate 600
Washington, DC 20037

Materials Available: Reports, reprints for professionals

Johnson Institute (612) 544-4165
10070 Olson Memorial Highway
Minneapolis, MN 55441

Materials Available: Pamphlets, booklets, reports

March of Dimes Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605

Materials Available: Pamphlets, fact sheets, reprints, A/Vs

National Cancer Institute (301) 496-4000
Cancer Information Clearinghouse
7910 Woodmont Avenue, Suite 1320
Bethesda, MD 20014

Materials Available: Information on tobacco products and smoking

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National Clearinghouse for Alcohol (301) 468-2600
and Drug Information
Department PP - P.O. Box 2345
Rockville, MD 20852

Materials Available: Pamphlets, books, posters, monographs, conference proceedings, reference material, audiovisuals, fact sheets, resource and curriculum guides, newsletters

National Council on Alcoholism (212) 986-4433
733 Third Avenue
New York, NY 10017

Materials Available: Pamphlets, fact sheets, A/Vs

National Federation of Parents for 1 (800) 544-KIDS
Drug-Free Youth
Suite 16
1820 Franwall Avenue
Silver Spring, MD 20902

Materials Available: Manuals, kits and brochures

National Highway Traffic Safety Administration (301) 962-3877
793 Elkridge Landing Road
Linthicum, MD 21090

Materials Available: Booklets, reports

National Library of Medicine (301) 496-4244
Reference Services Division
Videocassette Loan Program
8600 Rockville Pike
Bethesda, MD 20209

Materials Available: Video cassettes

Parents' Resource Institute for Drug Education (404) 658-2548
Volunteer Service Center, Suite 1216
100 Edgewood Avenue
Atlanta, GA 30303

Materials Available: Books, reprints, A/Vs

Society for Teachers of Family Medicine (800) 821-2512
c/o American Academy of Family Physicians
1740 W. 92nd Street
Kansas City, MO 64114

Materials Available: Curriculum guides, reports, literature reviews

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Wisconsin Clearinghouse (608) 263-2797
1954 East Washington Avenue
Madison, WI 53704-5291

Materials Available: Pamphlets, booklets, posters, A/Vs, curricula, resource reviews

B. Alcohol and Other Drug Audio-Visual Materials

Alcoholics Anonymous: An Inside View, 1979
28 minutes

Availability: Alcoholics Anonymous
Box 459
Grand Central Station
New York, NY 10163

Description: This video cassette takes the viewer inside AA meetings, from the smallest closed meetings to the large open ones.

Use: An excellent introduction to Alcoholics Anonymous; especially helpful for medical students prior to their visiting any AA meeting.

The Enablers, 1978
23 minutes

Availability: The Johnson Institute
10700 Olson Memorial Highway
Minneapolis, MN 55441

Description: The film examines the behavior of family and friends of an alcoholic woman and how it contributes to the continuation of her drinking. The film is the first of a two-part series with The Intervention.

Use: Good for demonstrating the dynamics of a chemically dependent family, a self-defeating pattern of interactions.

The Intervention, 1978
28 minutes

Availability: The Johnson Institute
10700 Olson Memorial Highway
Minneapolis, MN 55441

Description: Second in a series with The Enablers, family and friends work together for coercive, constructive confrontation of an alcoholic woman. The process of setting up such a confrontation is demonstrated, including the pitfalls to successful preparation.

Use: Excellent for supplementing The Enablers, for demonstrating enabling family dynamics, intervention, and teamwork. Also good for demonstrating how one can help a troubled family motivate a chemically dependent person to seek treatment.

The Neonatal Abstinence Syndrome: Diagnosis
10 minutes

Availability: Baylor College of Medicine
Career Teacher Center
1200 Moursund Avenue
Houston, TX 77030

Description: An excellent teaching film that presents a clinical demonstration of the signs and symptoms of neonatal abstinence syndrome.

Reading, Writing, and Reefer
52 minutes

Availability: Films Incorporated
733 Green Bay Road
Wilmette, IL 60091

Description: This video cassette examines the dramatic increase in the use of marijuana by children and the consequences to their physical and psychological health and well-being.

The Secret Love of Sandra Blain, 1976
27 minutes

Availability: Hollywood Enterprises
6060 Sunset Blvd.
Hollywood, CA 90028

Description: This film examines the story of a middle-class housewife whose drinking becomes obvious to her family and friends. Eventually the drinking problem becomes so severe that the woman can no longer deceive herself or those around her.

Use: An excellent introduction to alcoholism and the middle-class housewife. The film elucidates denial as one of the key factors in alcoholism.

Soft is the Heart of a Child, 1978
20 minutes

Availability: Operation Cork
P.O. Box 9550
San Diego, CA

Description: The film illustrates such themes as the family consequences of drinking, community paralysis, women as battered spouses and drinkers, children as victims, and the role of the school.

Use: Demonstrates the effects of alcoholism of the family, such as family violence, child abuse, and neglect. Highly recommended for medical students.

A Slight Drinking Problem, 1977
25 minutes

Availability: Norm Southerly Productions
1709 East 28th Street
Long Beach, CA 90806

Description: The troubles that befall an alcoholic are exacerbated by his wife's reactions and attempts to deal with him. With the help of Al-Anon, she begins to cope with her own life.

Use: Excellent for demonstrating the value of self-help groups such as Al-Anon.

MODULE I: SUBSTANCE ABUSE OVERVIEW

SUBSTANCE ABUSE OVERVIEW represents the basic introductory material that should be implemented first, prior to the other modules. In addition to introductory substance abuse content, this module serves as an example of how one can use specific learning activities to gain group endorsement around certain issues, set the stage for future teaching, plan future sessions using group input, and involve a group in a process of learning and consensus building.

In order to provide some choice of teaching to best match the needs of the audience, the resources of time, space, and people available, and the skill or comfort level of the presenter, two different teaching activities related to this "module" are contained within. After reviewing both, the most appropriate activity can be chosen for a particular group.

This module consists of two teaching activities through which students can fulfill specific objectives. Teaching Activity 1 allows the participant to take an active role in the learning process and is, therefore, the recommended method through which information about substance abuse overview should be implemented. However, if you do not have the time, students, teachers, space or other resources that are required to implement activity 1, another teaching activity is described herein. Both sessions are described generally below. For more detailed descriptions, see each teaching activity.

> Teaching Activity 1: Chemical Dependence: Individual and Family Characteristics - A Case Approach provides and effective and efficient mechanism through which important core information can be transmitted to students. Using a patient case, students examine personal attitudes, discuss basic concepts of substance abuse, and explore the role of the pediatrician.
>
> Teaching Activity 2: Chemical Dependence: Individual and Family Characteristics is a lecture that provides the same above content information but in the lecture format. This learning opportunity, although less effective for addressing attitudinal issues, is more appropriate when your target audience is more than 20 people.

TEACHING ACTIVITY 1

TITLE

CHEMICAL DEPENDENCE: INDIVIDUAL AND FAMILY CHARACTERISTICS
- A CASE APPROACH

FORMAT(S)

Case Discussion

SESSION GUIDELINES

Time:	1.5-2 hours
Prerequisites:	none
Space Recommendations:	arranging participants in a circle to facilitate discussion
Suggested Number of Participants:	10 - 15 is optimal number for small group discussions

OBJECTIVES

After participating in this session, participants will be able to:

- discuss the role of the pediatrician in the context of working with a substance using family
- identify requisite knowledge, attitudes and skills that would allow the pediatrician to fulfill his/her role
- explain the progression of substance abuse and the characteristics and family dynamics related to each of the four stages of use
- challenge his/her personal beliefs and prejudices related to substance abuse, including stereotypes, etiology and progression of the disease
- identify available resources in the treatment of a chemically dependent patient and/or family

RELATED CURRICULUM GOAL(S)

I. To increase awareness of general concepts of substance abuse.

III. To provide the basic skills to effectively intervene and engage the patient and family into treatment.

V. To promote awareness of the pediatrician's role in prevention.

SYNOPSIS

The purpose of this session is to engage participants in an active discourse of the general concepts of chemical dependency, and through such discussion, to establish by group consensus the pediatrician's role in working with patients and/or families harmfully involved with substances, and the concomitant fund of knowledge needed to function in that capacity. Specific content is also included within the case discussion that allows participants to identify and discuss personal beliefs and attitudes they might have around drug and alcohol issues. In total, participants should come to accept a conceptual framework in which to consider chemical dependency issues.

The success of the learning experience for the participants hinges on their willingness to actively participate in the discussion. To facilitate this process, the case is built around several teaching or focus points. Probe questions are provided so that the instructor may elicit information from the learners. Effective facilitation of this session depends on the instructor's knowledge of the participants moreso than the underlying details of the case. Prior to the session, the instructor should anticipate participant reactions, questions and comments about the case and the material and formulate positive and direct responses which will stimulate group discussion.

Gabel LL and Monk JS. Faculty Guide. In Gabel LL (ed): Adolescent alcoholism: Recognizing, intervening, and treating. U.S. Dept. of Health and Human Services, Contract Number: 240-83-0094.

Hostetler J. Adolescents and substance abuse: An overview. In Gabel LL (ed): Adolescent alcoholism: Recognizing, intervening, and treating. U.S. Dept. of Health and Human Services, Contract Number: 240-83-0094.

LeFager J. The double dilemma of chemically dependent parents and substance abusing adolescents. Focus on Family 1984; Nov/Dec:33-35.

MacDonald, DI: Drugs, drinking and adolescence. Amer J of Diseases of Children 1984; 138: 117-125.

MacDonald DI, Blume SB. Children of alcoholics. Amer J of Diseases of Children 1986; 140:750-754.

SESSION OUTLINE

Introduction	TT: 10 MIN.	RT: 10 MIN.

Introduction of Presenter(s) and Participants

Review Purpose and Objectives of Session [Handout 1]

Establish Ground Rules for Session

Review Materials

Case Review	TT: 55 MIN.	RT: 65 MIN.

A. Review Key Questions [Handout 2]

(Ask group to think about these questions as you proceed through case)

B. Begin Patient Case using IM [Handout 3]

1. Present case up to "STOP"
2. Ask Probe Questions from IM 1
3. Summarize participants opinions about confrontation using "Summary Statements" of IM 1

C. Resume Patient Case completing all of section 2

D. Using IM 2, focus discussion on role of pediatrician [Handout 6]

1. Ask Probe Questions from IM 2
2. Summarize participants opinions about pediatrician's role using "Summary Statements"

E. Using IM 3, focus discussion on progression of chemical dependency [Handout 4,5,7]

1. Review Handout 4,5,7

2. Review data about the father from IM - Patient Case Addendum

F. Using IM 4, focus discussion on need for awareness of treatment resources [Handout 10]

Evaluation (optional) TT: 5 MIN. RT: 70 MIN.

Hand out evaluations and ask participants to complete [Handout 14]

Summary and Closure TT: 5 MIN. RT: 75 MIN.

Refer back to objectives to determine if they were successfully completed. Summarize session. [Handout 1]

INSTRUCTOR'S MATERIALS

Instructor's Patient Case

IM 1 Teaching Point 1

IM 2 Teaching Point 2

IM 3 Teaching Point 3

IM 4 Patient Case Addendum - Data on the Father

IM 5 Teaching Point 4

All Learner's Materials are also Instructor's Materials:

Handout 1-Session Objectives

Handout 2-Key Questions

Handout 3-Patient Case

Handout 4-System Dynamics of the Alcoholic Family

Handout 5-Survival Roles

Handout 6-Knowledge and Skills Statements

Handout 7-Natural History of Alcoholism

Handout 8-Disease Model of Addiction

Handout 9-Adolescent Substance Abuse Progression

Handout 10-Example: Treatment Resource List

Handout 11-DSM-III R Criteria: abuse, dependence

Handout 12-C.A.S.T (Children of Alcoholics Screening Test)

Handout 13-Are Drugs a Problems for You?

Handout 14-Session Evaluation Form

TEACHING POINT # 1

PURPOSE: To facilitate the case and group discussion, several key teaching points have been identified. These teaching points, in keeping with the session objectives, will help you focus the discussion and help the group reach a concensus on many different points. For each teaching point probe questions to stimulate discussion, and content to facilitate learning, have been identified. Prior to the discussion, you should become familiar with the content in order to integrate it into the discussion.
DIRECTIONS: After reviewing case, ask PROBE QUESTIONS. Allow time for discussion, keeping participants focused by asking questions and directing conversation. Use summary points to reiterate what was discussed.

TEACHING POINT 1: CONFRONTATION IS UNCOMFORTABLE

PROBE QUESTIONS:

What do you think of this situation? Is this normal behavior on the part of the Dad?

Should the fact that the Dad smells of alcohol in the middle of the day be questioned?

Would anyone feel comfortable addressing his/her observation with the Dad? If not, why? Any alternative(s) available?

Do we need more information? How do we get this information?

If this were a repeated episode would it be appropriate to address the problem?

Why is it so difficult to intervene in these situations?

Is it appropriate to question Dad, Mother or siblings about the use of alcohol?

SUMMARY POINTS:

A. Confrontation is usually accompanied by a reaction

B. Confrontation usually enhances patient-physician relationship when done effectively

C. Confrontation and intervention become more comfortable, easier, and more effective as we become more familiar the disease process

Return to Patient Case - Section 2

TEACHING POINT #2

TEACHING POINT: PEDIATRICIAN HAS A ROLE

PROBE QUESTION:

Where in the case would it be appropriate for the pediatrician to establish a role?
Do you think the case would differ if:
(a) the father wore a business suit?
(b) the baby was healthy?

CONTENT:

In order to work with the family it's helpful to have in mind a conceptual framework of family systems

[Handout 4,5]

FAMILY ROLES

Hero
Scapegoat
Enabler
Lost Child
Mascot

Need minimal knowledge and skills dependent upon the role

[Handout6]

KNOWLEDGE AND SKILLS

Biochemistry and Pharmacology
Etiology
Epidemiology
Natural History
Diagnosis
Treatment
Prevention
Legal/Ethical Issues

Possible change in practice behavior
- routine inquiry of parental alcohol/drug use
- use of CAGE

C = cut down
A = annoyed
G = guilty
E = eye opener

Children may be asked how they feel about adults drinking

PACES/HEADS
Use/Concern

SUMMARY POINTS

A. Pediatricians are often only health care contact for family (as was the situation in this case)

B. Any role the pediatrician adopts requires certain knowledge and skills

C. Understanding of chemical dependence as a family disease is necessary before individuals can appreciate the importance of pediatricians working in this area

TEACHING POINT #3

TEACHING POINT: PROGRESSION IS PREDICTABLE

PROBE QUESTIONS:

1. Could this outcome have been predicted? Why?

2. Would knowing more about the disease process facilitate your handling of the case?

CONTENT: [review Handouts 6,7,8 with participants]

Read "Patient Case Addendum - Instructor's Material 4" to participants

SUMMARY POINTS:

A. Chronic disease nature of the problem

B. Alcohol and other drug abuse is treatable

C. Substance abuse has a predictable course:
-natural history
-family roles

D. Early intervention makes a difference

TEACHING POINT #4

TEACHING POINT: THERE ARE RESOURCES AVAILABLE FOR HELP

CONTENT: [review Handout 10 with participants]

YOU MAY ALSO WANT TO CREATE A HANDOUT THAT LISTS AVAILABLE TREATMENT RESOURCES IN YOUR AREA.

SUMMARY POINTS:

A. How to help

B. Who is out there?

C. What kinds of programs and resources are available?

D. How are these programs/resources accessed?

E. Creating a crisis

F. Approach

PATIENT CASE ADDENDUM

JOHNS HOPKINS HOSPITAL COMPREHENSIVE ALCOHOLISM PROGRAM
SUBSTANCE ABUSE EVALUATION

Patient's Name: Father

Clinical Condition at Presentation: Sober, complains of nervousness, gastrointestinal upset, probably initial withdrawal secondary to decreased amount.

Nature of Request: Patient requests "detox"; drinking out of control; negative past medical problems; positive past history "spitting up blood."

Current Meds Prescribed/Taken: none

History of Drug Use: none

Evidence of Current Alcohol Addition: Increased tolerance; increased amount; morning use with symptomatic relief; chronic daily heavy use; positive craving, loss of control, mild withdrawal symptoms on stopping alcohol: tremor, nausea, vomiting, sweats, anoxeria, insomnia, diarrhea/cramps.

Evidence of Other Addictions: none

Previous Treatment: none

Legal Status/Trial Dates: none

Current Motivation: Excellent = Family/Job dysfunction, 1 child gravely/chronically ill; patient has full insight!

Progress Note: 31 year old with strong past history of addictive disorder; last alcohol use 2 hrs. ago, 3 fifths of wine today; negative psychiatric history; usual use up to 8 fifths (with others) per day x 3 1/2 years with only 1 or 2 months of sobriety since then. First use at age 13; regular use at 17 years; problematic at 28 years; positive history of blackouts, negative delirium tremors, seizures.

Diagnostic Impression: 303.9 Alcohol Dependence/Gamma

Disposition, Reason for Referral: Hospitalization for medically supervised detoxification followed by outpatient counseling on long term basis.

SESSION OBJECTIVES

After participating in this session, participants will be able to:

1. discuss the role of the pediatrician in the context of working with a substance using family

2. identify requisite knowledge, attitudes and skills that would allow the pediatrician to fulfill his/her role

3. explain the progression of substance abuse and the characteristics and family dynamics related to each of the stages of use

4. challenge his/her personal beliefs and prejudices related to substance abuse, including stereotypes, etiology and progression of the disease

5. identify and work together with available resources in the treatment of a chemically dependent patient and/or family

KEY QUESTIONS

1. Do I fully comprehend the magnitude of the problem of alcoholism and drug abuse?

2. Do I possess the skills and knowledge necessary to help address this problem?

3. Do I want to develop such skills and attain such knowledge?

4. Do I recognize my strengths and limitations as related to dealing with alcoholism and drug abuse problems?

5. Do I know how to capitalize on my strengths and overcome my limitations as I address the problem of alcoholism and drug abuse?

[From Gabel LL, Monk JS. Faculty Guide in Adolescent Alcoholism: Recognizing, Intervening, and Treating. Gabel LL (ed). Department of Family Medicine, The Ohio State University, Columbus, Ohio 43210]

PATIENT CASE

Patient Profile

Index patient is now a 10 month old female born with severe birth asphyxia resulting in multiple problems including hydrocephalus and severely compromised neurologic status, developmental, motor and mental retardation. Despite the problems of the immediate newborn course, the infant is at present stable and at home under the care of both parents.

Family Profile

Mother: 31 year old female reported to have medical problems as a child necessitating cardiac surgery; currently in good health

Father: 31 year old male reportedly in good health

Siblings:

1) 10 year old male - hyperactive
2) 8 year old male - doing well
3) 22 month old female - good health, questionably somewhat withdrawn

Social History

Intact family, parents married for 11 years

Mother dropped out of high school in 10th grade due to medical problems; plans to obtain high school diploma

Father completed high school, is a veteran, and currently works as a counselor with delinquent boys

On first encounter with the father during the day when the child is admitted to the NICU he is noted to be well dressed, polite and appropriately concerned. The father had been in attendance at the outside hospital when the infant was born by emergency Cesarean section and he escorted the infant to the hospital. He had the distinct smell of alcohol on his breath which was noticed by several members of the health care team.

PATIENT CASE

Interval Follow-Up

The infant had a hospital course which concluded after 1 $^{1}/_{2}$ months. During the family discussion sessions and discharge planning, it was very difficult to contact the father although the mother was available at all sessions and related that all at home was well. Multiple attempts to get the father involved have failed. Finally, a cab was sent to his home in order to bring him in for a discharge planning session.

On discharge from the hospital there were frequent follow-up visits during which the patient was accompanied by the mother only.

At 3 months of age the patient was again admitted to the hospital for various medical complications and neurosurgical interventions including placement of a VP shunt. This prolonged stay encompassed two months during which time the family had active support from various staff and frequent support meetings with social work. During this time there was raised some suspicion about the father's use of alcohol amongst staff members, but this was not acted upon.

In the interim the father became unemployed and increasingly unavailable. There was evidence of increasing family stress. Following the second hospital discharge, the mother again was noted to be very diligent about follow-up and appeared to be coping very well despite adverse situations.

On a routine call from the pediatrician to the mother, she related that she was very concerned about the health of her husband. The mother acknowledged that he had had a slight drinking problem long ago and was once again drinking. The father was noted to be experiencing bad dreams, occasional emesis of blood, pacing when at home and was also out a lot of the time.

Upon hearing this the pediatrician acknowledged feeling somewhat frustrated and guilty and pondered over how to pursue this matter.

PATIENT CASE

Several weeks later the mother called the pediatrician in desperation and asked for help. Several crisis events have occurred:
-the father had spent the money from the infant's disability check;
-there had been increased tension between the parents; and
-the younger daughter stumbled upon some drug paraphernalia which was left in the house by friends of the father.

Handout 4

SYSTEM DYNAMICS OF THE ALCOHOLIC FAMILY

ROLE	MOTIVATING FEELING	IDENTIFYING SYMPTOMS	PAYOFF		POSSIBLE PRICE
			FOR INDIVIDUAL	FOR FAMILY	
DEPENDENT	Shame	Chemical Use	Relief of pain	None	Addiction
ENABLER	Anger	Powerlessness	Importance; self-righteousness	Responsibility	Illness; "Martyrdom"
HERO	Inadequacy; guilt	Overachievement	Attention (positive)	Self-worth	Compulsive drive
SCAPEGOAT destruction;	Hurt	Delinquency	Attention (negative)	Focus away from Alcoholic	Self- addiction
LOST CHILD	Loneliness	Solitariness; shyness	Escape	Relief	Social isolation
MASCOT	Fear	Clowning; hyperactivity	Attention (amused)	Fun	Immaturity; emotional illness

[From Another Chance: Hope and Health for Alcoholic Families by Sharon Wegscheider]

I - V 20

SURVIVAL ROLES

In the alcoholic family, all members of the family are affected by the growing inability of the alcoholic to function. Family members learn to cope with the growing instability in the family by adopting roles. These roles are attempts to lessen the personal stress — to protect oneself from being hurt. By adopting these roles, family members increasingly hide their feelings becoming less aware of what their feelings really are.

THE HERO:

The hero is often the oldest child, knows what is really going on in the family and tries hard to improve the situation. The hero begins to feel responsible for the family pain but continually is frustrated in efforts to better things. This family member is hard driven and outwardly successful. The hero feels inadequate inside.

THE SCAPEGOAT:

The scapegoat is usually a younger child, who pulls away from the family and develops a strong peer group attachment to acquire a feeling of belonging. By acting in destructive ways, this family member is often blamed for the family chaos, providing a diversion from the real problem — alcoholism. The scapegoat feels hurt inside.

THE LOST CHILD:

The lost child is also, most often, a younger or youngest child. The lost child adopts a "safe" role — to be as little trouble and avoid as much notice as possible. The lost child is overlooked, being quietly busy — spending much time by themselves often fantasizing or day dreaming. The lost child feels lonely inside.

THE MASCOT:

The mascot may be any family member. The mascot deals with the tension in the family by being charming and humorous. The mascot feels fear inside.

THE ENABLER:

The enabler is usually the spouse or a parent, the person closest to and most depended on by the alcoholic. But anyone in the alcoholic's world may be an enabler. The enabler is someone who, without knowing it, helps the drinker to continue drinking. The enabler has understandable and sometimes "good" reasons for being an enabler: to try to "cure" the drinker — to keep the family together — to solve problems. This survival role helps the enabler to cope and to continue to function. The enabler feels resentful inside.

CORE MINIMAL KNOWLEDGE AND SKILLS IN SUBSTANCE ABUSE

Introduction

The purpose of this document is to broadly describe the minimum knowledge and skills in alcohol and other drug abuse for practicing physicians including general internists, psychiatrists, family physicians, and pediatricians. This body of knowledge is being presented because the practicing physician is at the forefront of prevention and management of this important problem.

The physician should accept alcoholism and other drug abuse as medical disorders. He or she should be informed about substance abuse disorders; recognize the effect on the patient, the family, and the community; and should be able to diagnose and treat these disorders. The physician should recognize his or her own personal strengths and limitations in managing patients with substance abuse.

Medical students should be aware of the prevalence of patients with substance abuse in all medical settings. Students should have the same fund of knowledge in this area, as practicing physicians. Students should also be capable of screening for substance abuse in the course of performing a history and physical examination and should be able to take a detailed alcohol or drug use history when appropriate. Students should be aware of different treatment modalities and their expected outcomes, but are not expected to have the skills necessary to treat patients for their primary problem.

A. General Concepts

The practicing physician should understand the following general concepts related to alcohol and other drug abuse:

1. Common definitions
2. Diagnostic criteria
3. Epidemiology and natural history
4. Risk factors including familial and social cultural factors, as well as current genetic and biologic theories.
5. The relationship of this group of disorders to the functioning of the family.

B. Prevention

The practicing physician should understand his or her role in prevention of alcohol and other drug abuse problems through patient education, risk identification and prescribing practices.

C. Pharmacology and Pathophysiology

The practicing physician should understand:

1. The pharmacology and behavioral effects of commonly abused substances.

2. The physiology of intoxication, dependence, tolerance, and withdrawal.
3. Pathological effects of acute and chronic drug and alcohol abuse on organ systems.

D. Evaluation of the Patient

The practicing physician should be aware of specific presenting complaints suggestive of substance abuse. In addition, physicians should be able to screen effectively for the early and late manifestations of substance abuse including behavioral manifestations. Once substance abuse is suspected in an individual patient, physicians should be able to confirm the diagnosis by obtaining a detailed alcohol and drug use history, identifying physical findings suggestive of substance abuse, and interpreting the results of selected laboratory tests.

The practicing physician should be aware that substance abuse disorders may present as other medical or psychiatric disorders or may be complicated by the presence of psychiatric or medical comorbidity.

The practicing physician should be aware that denial in the patient, family, and physician delay recognition and treatment.

E. Patient Management

The practicing physician should be able to directly manage or refer patients for treatment of acute intoxication, overdose, and withdrawal. He or she should be able to motivate the patient for further treatment and select an appropriate management plan from available treatment options, bearing in mind the patient needs and community resources. He or she should be knowledgeable of the various treatment alternatives and the expected outcomes of treatment.

The physician should recognize his or her responsibility in the long-term management and follow-up of patients with substance abuse.

The practicing physician should be familiar with the philosophy and availability of self help groups for the patient and family, such as AA and Al-Anon.

F. Legal and Ethical Aspects

The practicing physician should know the legal aspects of informed consent, release of information, and of obtaining blood, urine, and breath tests in screening for alcohol and other drug use.

The physician should be knowledgeable of the laws and regulations governing the use of controlled substances.

G. Health Professional Impairment

The practicing physician should be aware of health professionals as a group at risk for alcohol and drug problems and be aware of the resources available for impaired colleagues.

THE NATURAL HISTORY OF ALCCHOLISM

Stage 1. Normal Drinking

The individual drinks alcoholic beverages without negative physical or emotional consequences. There is no preoccupation with drinking, and there are no efforts to control alcohol intake.

Stage 2. Preoccupation with Drinking

The person is pleased with his drinking behavior and believes that alcohol makes life better. He often thinks about drinking (what, where, when, etc.).

Stage 3. Preoccupation with Controlling Drinking

The drinker is trying to return to Stage 1. His attempts to cut down or to stop drinking usually result in repeated failures.

Stage 4. Preoccupation with Stopping Drinking

This stage is characterized by alternating periods of drinking alcohol and periods of total abstinence. When the alcoholic is in treatment and beginning the process of recovery, these occasional short relapses can be expected for up to five years.

Stage 5. Total Abstinence and Improved Coping With the Stresses of Everyday Life

Most alcoholics move into this final stage only after participating in some form of treatment. The individual is now enjoying a more productive, satisfying life with improved emotional and physical health.

[adapted from C. Whitfield]

THE DISEASE MODEL OF ALCOHOLISM

Alcoholism is a Primary Illness

About 90 percent of alcoholics seem to have problems which are a result of active drinking. Other alcoholics may have a dual diagnosis (e.g., alcoholism plus a psychiatric disorder). Primary alcoholism occurs when no pre-existing psychopathology has been observed; secondary alcoholism is seen when a person with a major psychiatric disorder develops the symptoms of alcoholism.

Alcoholism is a Chronic Disease

Those who have the disease are moved into a state of recovery through treatment, but they are never "cured" any more than an adult-onset diabetic is cured. The goal of treatment and aftercare is to promote longer and longer periods of sobriety. Returning to moderate or "controlled" drinking has not proven to be a viable option for primary alcoholics. The chronic nature of the affliction mandates careful follow-up when working with alcoholic patients and their families. Relapse is common.

Alcoholism is a Progressive Disease

As long as the alcoholic continues to drink, the symptoms of the disease and the physical, social, and psychological problems of the individual will become more severe.

Alcoholism is an Addictive Illness

The addictive nature of the disease, including the involvement of individuals other than the patient, is easily recognized when the physician observes that, in spite of all the negative consequences which result from alcohol intake, the alcoholic continues to drink.

Alcoholism is a Fatal Disease

Treated, alcoholism can be controlled, and patients recover; left untreated, alcoholism has a very high mortality rate and is associated with a long list of complications.

ADOLESCENT SUBSTANCE ABUSE PROGRESSION

STAGE 1: EXPERIMENTATION LEARNING THE MOOD SWING	PREDISPOSITION	BEHAVIOR	FAMILY REACTION
Infrequent use Alcohol/pot/inhalants No consequences Some fear of use Low tolerance	Curiosity Peer pressure Attempt to assume adult role	Learning the mood Feels good Positive reinforcement Can return to normal	Often unaware Denial
STAGE 2: SEEKING THE MOOD SWING			
Increasing frequency Use of various drugs Minimal defensiveness Tolerance	Impress others Social function Pride in amount consumed	Using to get high Use other than weekend Use to relieve feelings Denial of problem	Attempts at elimination Blaming others
STAGE 3: PREOCCUPATION WITH THE MOOD SWING			
Change in peer group Activities revolve around use Steady supply Possible dealing Few/no straight friends Consequences occur more frequently	Using to get loaded-not just high	Begins to violate values and rules Use before and during school Use despite consequence Solitary use Trouble with school Overdoses, "bad trips", blackouts Promises to cut down or attempts to quit Protection of supply, hides use from peers Deterioration in physical condition	Conspiracy of silence Confrontation Reorganization with or without affected individual
STAGE 4: USING TO FEEL NORMAL			
Continued use despite adverse outcomes Loss of control Inability to stop Compulsion	Use to feel normal	Daily use Failure to meet expectations Loss of control Paranoia Suicide gestures, self-hate Physical deterioration (poor eating and sleep habits)	Frustration Anger May give up

[EXAMPLE OF A] TREATMENT RESOURCE LIST

SOURCES OF INFORMATION ON TREATMENT

A. Local Phone Book

B. Local Health Department

C. State Alcohol and Drug Abuse Administration

D. Specific Organizations

1. Narcotics Anonymous (NA)
2. Alcoholics Anonymous (AA)
3. Al-Anon
4. Al-Ateen
5. National Council on Alcoholism
6. National Institute on Alcoholism and Alcohol Abuse
7. National Institute on Drug Abuse

DSM-III R CRITERIA
FOR SUBSTANCE ABUSE AND DEPENDENCE

DIAGNOSTIC CRITERIA FOR PSYCHOACTIVE SUBSTANCE ABUSE

A. A maladaptive pattern of psychoactive substance use indicated by at least one of the following:

(1) continued use despite knowledge of having a persistent of recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance

(2) recurrent use in situations in which use is physically hazardous (e.g.,d driving while intoxicated)

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.

C. Never met the criteria for Psychoactive Substance Dependence for this substance.

DIAGNOSTIC CRITERIA FOR PSYCHOACTIVE SUBSTANCE DEPENDENCE

A. At least three of the following:

(1) substance often taken in large amounts or over a longer period than the person intended

(2) persistent desire or one or more unsuccessful efforts to cut down or control substance use

(3) a great dear of time spent in activities necessary to get the substance (e.g., theft), taking the substance (e.g., chain smoking), or recovering from its effects

(4) frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school, or home (e.g., does not go to work because hung over, goes to school or work "high," intoxicated while taking care of his or her children), or when substance use is physically hazardous (e.g., drives when intoxicated)

(5) important social, occupational, or recreational activities given up or reduced because of substance use

(6) continued substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by the use of the substance (e.g., keeps using heroin despite family arguments about it, cocaine-induced depression, or having an ulcer made worse by drinking)

(7) marked tolerance: need for markedly increased amounts of the substance (i.e., at least 50% increase) in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount

NOTE: The following items may not apply to cannabis, hallucinogens, or phencyclidine (PCP):

(8) characteristic withdrawal symptoms (see specific withdrawal syndromes under Psychoactive Substance-induced Organic Mental Disorders)

(9) substance often taken to relieve or avoid withdrawal symptoms

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.

CHILDREN OF ALCOHOLICS SCREENING TEST

Please check the answer below that best describes your feelings, behavior, and experiences related to a parent's alcohol use. Take your time and be as accurate as possible. Answer all 30 questions by checking either "yes" or "no".

Sex: Male _____ Female _____ Age

YES	NO		
____	____	1.	Have you ever thought that one of your parents had a drinking problem?
____	____	2.	Have you ever lost sleep because of a parent's drinking?
____	____	3.	Did you ever encourage one of your parents to quit drinking?
____	____	4.	Did you ever feel alone, scared, nervous, angry, or frustrated because a parent was not able to stop drinking?
____	____	5.	Did you ever argue or fight with a parent when he or she was drinking?
____	____	6.	did you ever threaten to run away from home because of a parent's drinking?
____	____	7.	Has a parent ever yelled at or hit you or other family members when drinking?
____	____	8.	Have you ever heard your parents fight when one of them was drunk?
____	____	9.	Did you ever feel like hiding or emptying a parent's bottle of liquor?
____	____	10.	Did you ever protect another family member from a parent who was drinking?
____	____	11.	Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?
____	____	12.	Did you ever wish that a parent would stop drinking?
____	____	13.	Did you ever feel responsible for and guilty about a parent's drinking?
____	____	14.	Did you ever fear that your parents would get divorced due to alcohol misuse?

YES N

___ ___ 15. Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?

___ ___ 16. Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?

___ ___ 17. Did you ever feel that you made a parent drink alcohol?

___ ___ 18. Have you ever felt that a problem drinking parent did not really love you?

___ ___ 19. Did you ever resent a parent's drinking?

___ ___ 20. Have you ever worried about a parent's health because of his or her alcohol use?

___ ___ 21. Have you ever been blamed for a parent's drinking?

___ ___ 22. Did you ever think your father was an alcoholic?

___ ___ 23. Did you ever wish your home could be more like the homes of your friends who did not have a patent with a drinking problem?

___ ___ 24. Did a parent ever make promises to you that he or she did not keep because of drinking?

___ ___ 25. Did you ever think your mother was an alcoholic?

___ ___ 26. Did you ever wish that you could talk to someone who could understand and help the alcohol-related problems in your family?

___ ___ 27. Did you ever fight with your brothers and sisters about a parent's drinking?

___ ___ 28. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?

___ ___ 29. Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?

___ ___ 30. Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?

_____ TOTAL NUMBER OF "YES" ANSWERS

Score of 6 or more means that more than likely this child is a child of an alcoholic parent.

ARE DRUGS A PROBLEM FOR YOU?

The following checklists are far from complete. Each drug has its own special signs. You can probably devise more appropriate questions of your own. But, these should give you a clue to what you ought to be asking yourself about your drug use and its impact on the rest of your life.

DRUG USE CHECKLIST:

1. Do you use drugs when you are alone?
2. Can you turn down a joint or a line of coke if it is offered?
3. Do you get high before seeing non-using friends?
4. Do you need something (a joint, a tranquilizer or something stronger) before going to sleep?
5. Do you ever take something (a drink, a joint, a stimulant) first thing in the morning?
6. Do you feel nervous, flat and dull when you are not using?
7. How large a supply do you keep, and how concerned do you become when you start to run out?
8. Can you get through a full day without drugs and feel no distress?
9. Is it becoming difficult to pay for all the drugs you want?

IMPACT CHECKLIST:

1. Do you have many non-using friends?
2. How many of your drug buddies would you want as friends if you stopped using?
3. Is there more friction in your dealings with friends and co-workers than before you used drugs?
4. Is your boss (teacher) less interested in your work?
5. Are your grades falling?
6. Did you get the last raise you thought you deserved?
7. Do you have less patience for detail and find it harder to master new material?
8. Do you often find yourself re-reading the same page?
9. Are there many times when you lose track of conversations?
10. Are you sexually aroused less frequently?

ARE DRUGS A PROBLEM FOR YOU?
(continued)

11. Do you believe sex is better when you are high?

12. Are you interested in sustaining a relationship?

13. Do you feel you give as much as your partner to your marriage or your relationship?

14. How does he or she feel about your drug use and your relationship?

The wrong answers are obvious. Any wrong answer should cause you to question how much control you are exercising over drug use and how other parts of your life are being affected. Some answers may indicate other problems. Clearly, if you spend a good part of your time high or often become intoxicated, miss work or school, or go off on binges, no checklist is needed.

[Extracted from "How to Get Off Drugs" by Ira Mothner and Alan Weitz, 1984]

Session Evaluation

For each question please circle the most appropriate answer.

1. Prior to the presentation, I would have described my knowledge of the relationship between family dynamics and chemical dependence as:

   1 = Inadequate 2 = Adequate 3 = More than Adequate

2. As a result of this presentation, my knowledge of family systems and individual roles within substance abusing families has improved.

   1 = Strongly Disagree
   2 = Disagree
   3 = Agree
   4 = Strongly Agree

3. Most of the material covered was <u>new</u> to me?

   1 = Disagree 2 = Agree

4. The case presentation was:

	Disagree	Agree
a. interesting	1	2
b. well organized	1	2

5. The discussion conducted during the session helped clarify the material covered in the presentation.

   1 = Strongly Disagree
   2 = Disagree
   3 = Agree
   4 = Strongly Agree

6. The interaction between the presenters and the participants was good.

   1 = Strongly Disagree
   2 = Disagree
   3 = Agree
   4 = Strongly Agree

7. What individual/family chemical dependency issues would you like to learn more about in future sessions?

8. What issues were covered in more detail (or at greater length) than you felt necessary?

9. Would you be interested in attending additional sessions on other aspects of substance use and abuse?

1 = NO 2 = YES

10. Of the following times for future sessions, please indicate which one(s) you could attend.

	NO	YES
a. a 5:00pm session	1	2
b. a morning session	1	2
c. a noon time session	1	2
d. a weekend session	1	2
e. other _____	1	2

10. Please circle the letter (a-e) of the time you most prefer.

11. Would you be willing to critically evaluate this session with project staff at a later date.

1 = NO 2 = YES

12. COMMENTS:

SUGGESTED PREPARATION ACTIVITIES

____ Assign required readings

____ Advertise session if it is not required

____ Familiarize self with all handouts, especially Handout 1, 4 and 8)

____ Review articles on conducting case discussions (Gabel reference)

____ Develop student packets (contains all handouts, including objectives, recommended reading lists, and evaluation)

____ Assess the needs, knowledge level, perceptions and related practice behaviors of the audience

____ Develop list of treatment resources available within the institution or community (refer to handout 5 as a proposed outline for such a list)

____ Determine need for audio-visual equipment

____ Make copies of session evaluation

TEACHING ACTIVITY 2

TITLE

CHEMICAL DEPENDENCE: INDIVIDUAL AND FAMILY CHARACTERISTICS

FORMAT(S)

Lecture

SESSION GUIDELINES

Time:	1 hour
Prerequisites:	none
Space Recommendations:	none
Suggested Number of Participants:	20 and above

OBJECTIVES

After participating in this session, participants will be able to:

- better understand the magnitude of alcohol and other drug problems within the pediatric population and recognize then as important health problems in children, adolescents and adults
- explain the natural history of substance abuse and the characteristics and family dynamics related to each of the four stages of use
- recognize substance abuse as a progressive illness

RELATED CURRICULUM GOAL(S)

I. To increase awareness of general concepts of substance abuse.

III. To provide the basic skills to effectively intervene and engage the patient and family into treatment.

V. To promote awareness of the pediatrician's role in prevention.

SYNOPSIS

The purpose of disseminate basic introductory content about alcohol and drug issues. General concepts of chemical dependency including epidemiology, natural history, and progression of substance abuse is reviewed.

INSTRUCTOR'S RESOURCES

Gabel LL and Monk JS. Faculty Guide. In Gabel LL (ed): Adolescent alcoholism: Recognizing, intervening, and treating. U.S. Dept. of Health and Human Services, Contract Number: 240-83-0094.

Hostetler J. Adolescents and substance abuse: An overview. In Gabel LL (ed): Adolescent alcoholism: Recognizing, intervening, and treating. U.S. Dept. of Health and Human Services, Contract Number: 240-83-0094.

LeFager J. The double dilemma of chemically dependent parents and substance abusing adolescents. Focus on Family 1984; Nov/Dec:33-35.

MacDonald DI: Drugs, drinking and adolescence. Amer J of Diseases of Children 1984; 138: 117-125.

MacDonald DI, Blume SB. Children of alcoholics. Amer J of Diseases of Children 1986; 140:750-754.

INSTRUCTOR'S OUTLINE

Introduction	TT: 5 MIN.	RT: 5 MIN.

Introduction of Presenter(s) and Participants

Review Purpose and Objectives of Session [Handout 1]

Establish Ground Rules for Session

Review Materials

Slide Presentation	TT: 35 MIN.	RT: 40 MIN.

A. EPIDEMIOLOGY

1. Slide 1 - High school drug survey
2. Slide 2 - Prevalence and recency of use
3. Slide 3 - Thirty-day prevalence of daily use
4. Slide 4 - Non-continuation Rates...
5. Slide 5 - Trends in two-week prevalence of heavy drinking by sex
6. Slide 6 - Figure C...
7. Slide 7 - Proportion of friends using each drug...
8. Slide 8 - Trends in perceived availability of drugs
9. Slide 9 - Drinking patterns of high school seniors
10. Slide 10 - Where teenagers drink
11. Slide 11 - Percent of Maryland adolescents using substances...
12. Slide 12 - Percent of...reporting current use...by grade last year
13. Slide 13 - Percent of...reporting current use...by race/ethnicity
14. Slide 14 - Percent of...reporting current use of substances
15. Slide 15 - Substance abuse prevalence summary

B. NATURAL HISTORY

1. Slide 16 - Spectrum of adolescent drug abuse
2. Slide 17 - Stage 1: Experimentation...
3. Slide 18 - Stage 2: Seeking the mood swing
4. Slide 19 - Stage 3: Preoccupation...Characteristics
5. Slide 20 - Stage 3: Preoccupation...Behavior
6. Slide 21 - Stage 4: Using to feel normal

C. RISK FACTORS

1. Slide 22 - Risk factors for drug abuse
2. Slide 23 - Drug abuse warning signs [Handout 7]
3. Slide 24 - Substance abuse screening

4. Slide 25 - Taking a drug history from teenagers
5. Slide 26 - C.A.G.E questions

Discussion	TT: 10 MIN.	RT: 50 MIN.

D. TREATMENT AND INTERVENTION
1. Slide 27 - Intervention strategies
2. Treatment resources [Handout 10]

Evaluation (optional)	TT: 5 MIN.	RT: 55 MIN.

Hand out evaluations and ask participants to complete

Summary and Closure	TT: 5 MIN.	RT: 75 MIN.

Refer back to objectives to determine if they were successfully completed. Summarize session. [Handout 1]

Slide 1 - High school drug survey
Slide 2 - Prevalence and recency of use
Slide 3 - Thirty-day prevalence of daily use
Slide 4 - Noncontinuation Rates...
Slide 5 - Trends in two-week prevalence of heavy drinking by sex
Slide 6 - Figure C...
Slide 7 - Proportion of friends using each drug...
Slide 8 - Trends in perceived availability of drugs
Slide 9 - Drinking patterns of high school seniors
Slide 10 - Where teenagers drink
Slide 11 - Percent of Maryland adolescents using substances...
Slide 12 - Percent of...reporting current use...by grade last year
Slide 13 - Percent of...reporting current use...by race/ethnicity
Slide 14 - Percent of...reporting current use of substances
Slide 15 - Substance abuse prevalence summary
Slide 16 - Spectrum of adolescent drug abuse
Slide 17 - Stage 1: Experimentation...
Slide 18 - Stage 2: Seeking the mood swing
Slide 19 - Stage 3: Preoccupation...Characteristics
Slide 20 - Stage 3: Preoccupation...Behavior
Slide 21 - Stage 4: Using to feel normal
Slide 22 - Risk factors for drug abuse
Slide 23 - Drug abuse warning signs
Slide 24 - Substance abuse screening
Slide 25 - Taking a drug history from teenagers
Slide 26 - C.A.G.E questions

The following Learner's Materials are also to be used by the instructor (copies of these are included in Teaching Activity 1 of Module I):

Handout 1 - Session Objectives

Handout 7 - Natural History of Alcoholism

Handout 9 - Adolescent Substance Abuse Development Curve

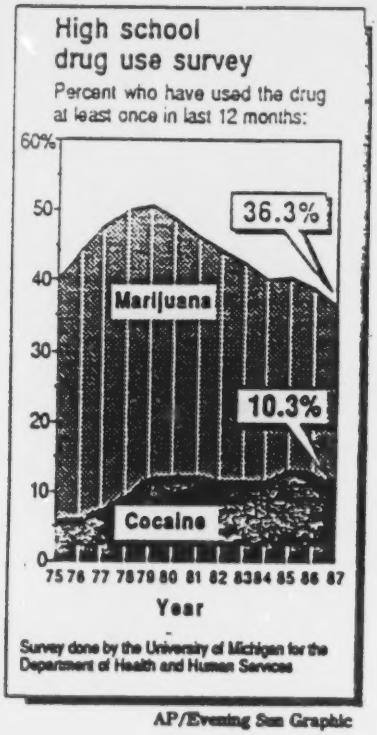
Handout 10 - Example: Treatment Resource List

Handout 11 - DSM-III R Criteria: abuse, dependence

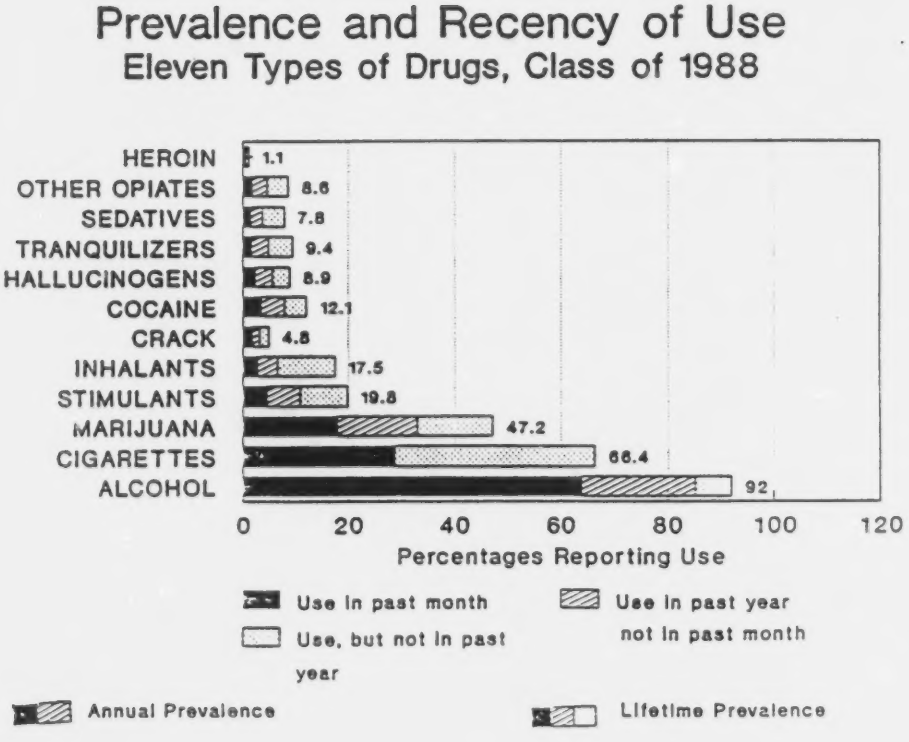
Handout 12 - C.A.S.T. (Children of Alcoholics Screening Test)

Handout 13 - Are Drugs a Problem for You?

Slide 1

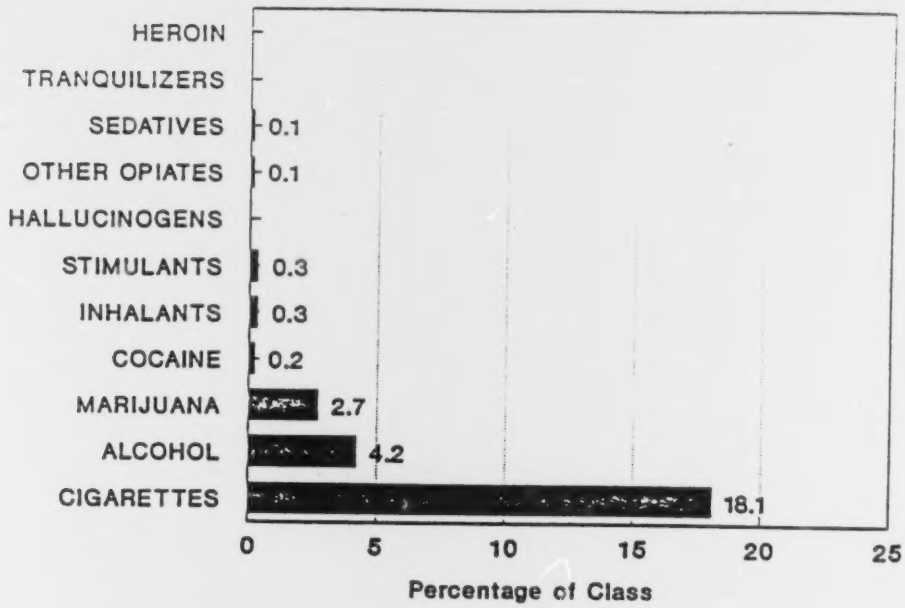


Slide 2



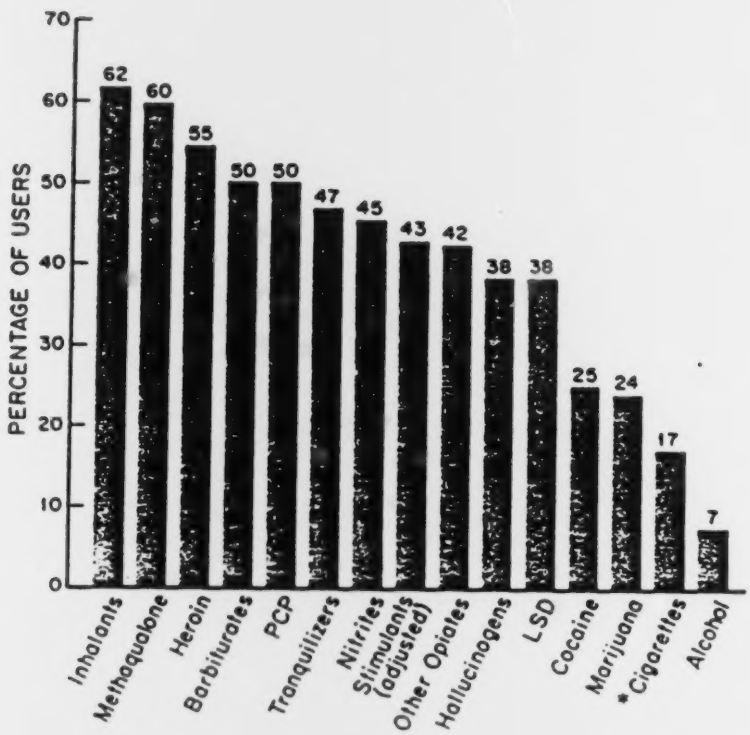
Slide 3

Thirty-Day Prevalence of Daily Use
Eleven Types of Drugs, Class of 1988



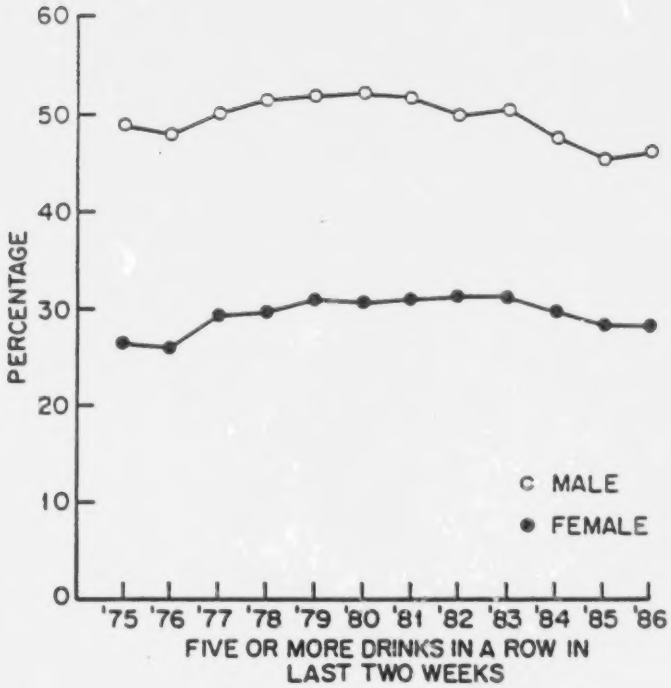
Slide 4

Noncontinuation Rates: Percent of Seniors Who Used Drug Once or More in Lifetime but Did Not Use in Past Year

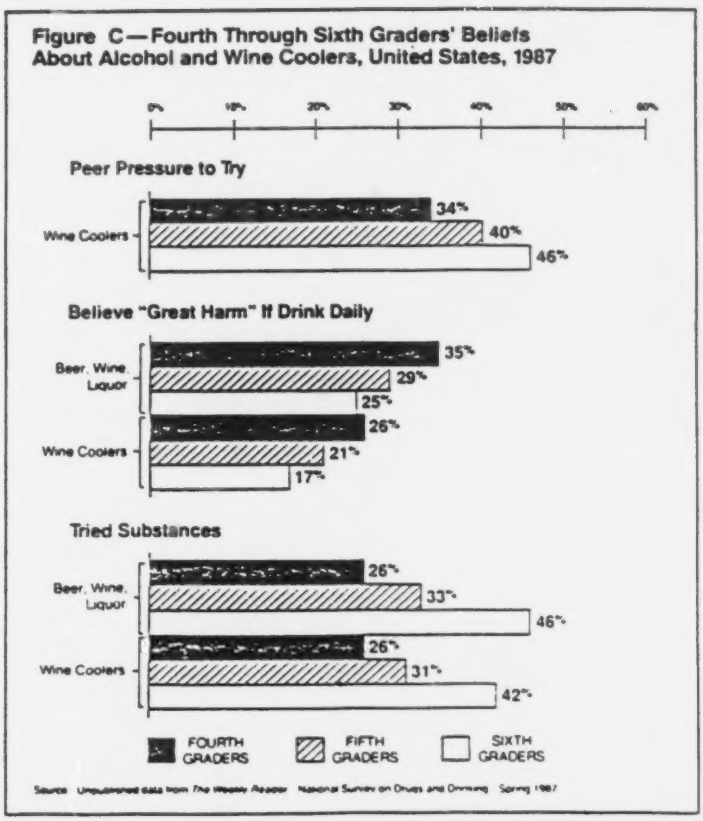


Slide 5

Trends in Two-Week Prevalence of Heavy Drinking by Sex

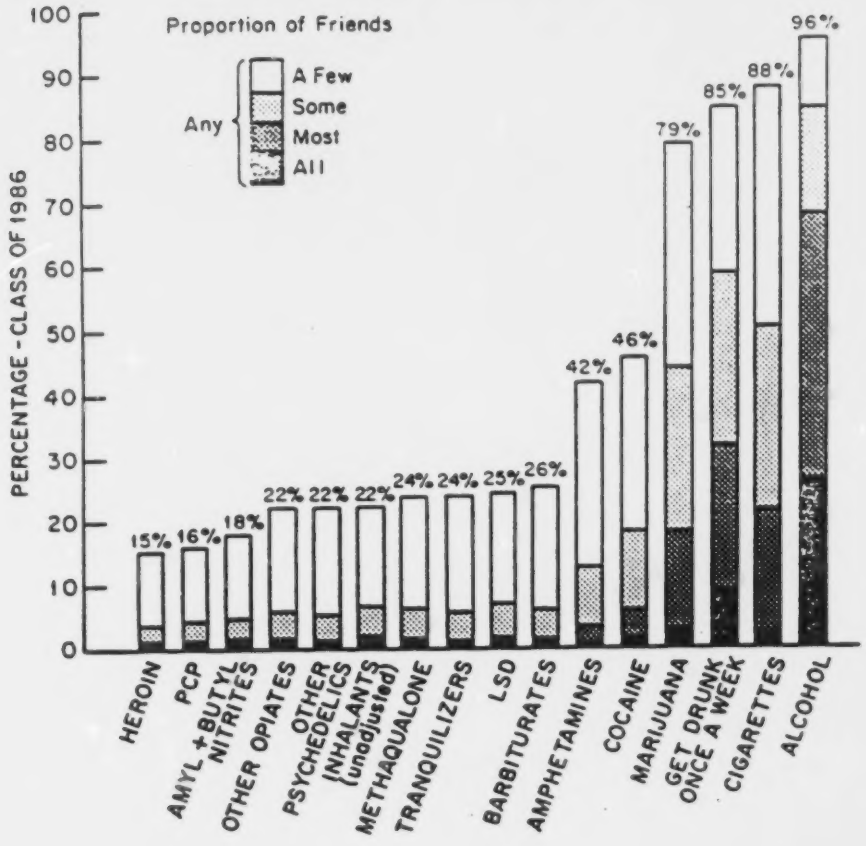


Slide 6



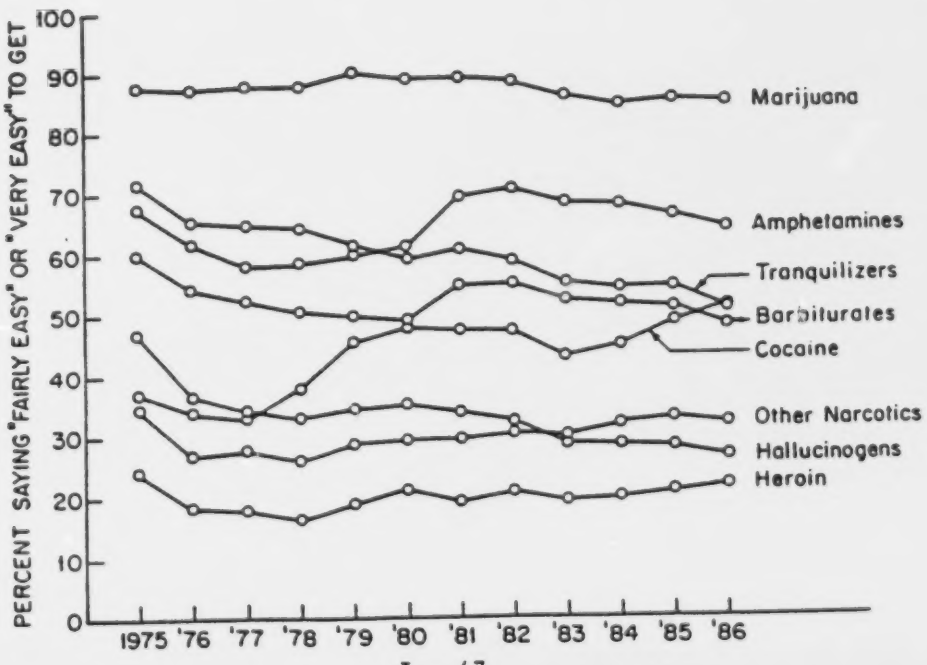
Slide 7

Proportion of Friends Using Each Drug as Estimated by Seniors, in 1986

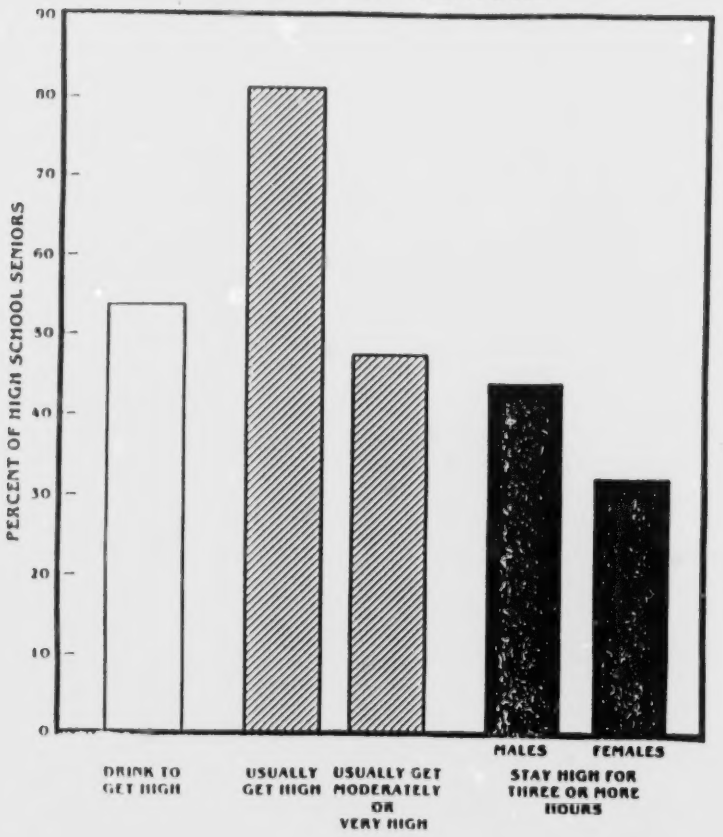


Slide 8

Trends in Perceived Availability of Drugs

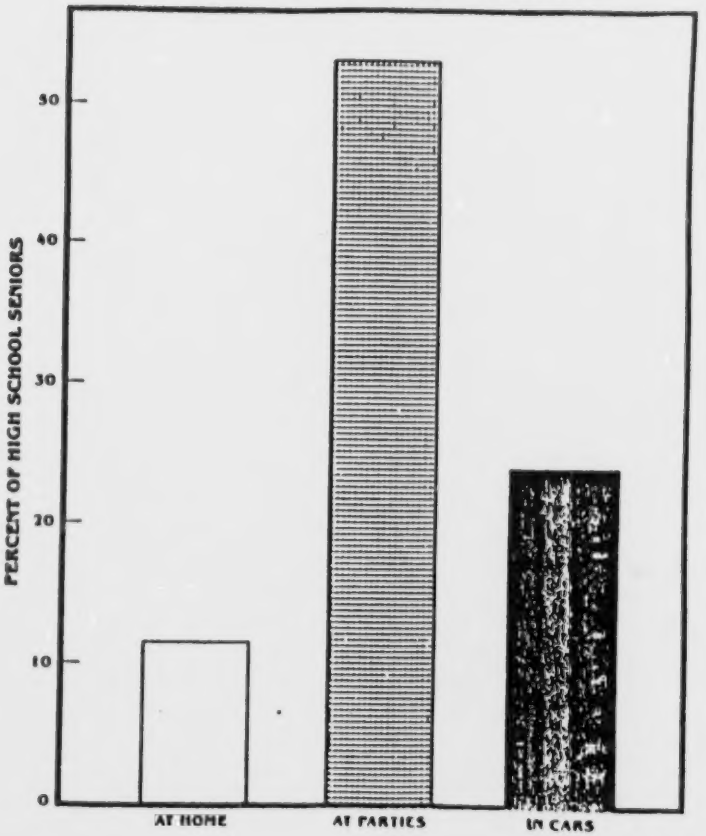


DRINKING PATTERNS OF HIGH SCHOOL SENIORS



Slide 9

WHERE TEENAGERS DRINK



Slide 10

Slide 11

Percent Of Maryland Adolescents Who Currently Use Drugs Or Alcohol--Statewide Estimates--1986-87 Survey

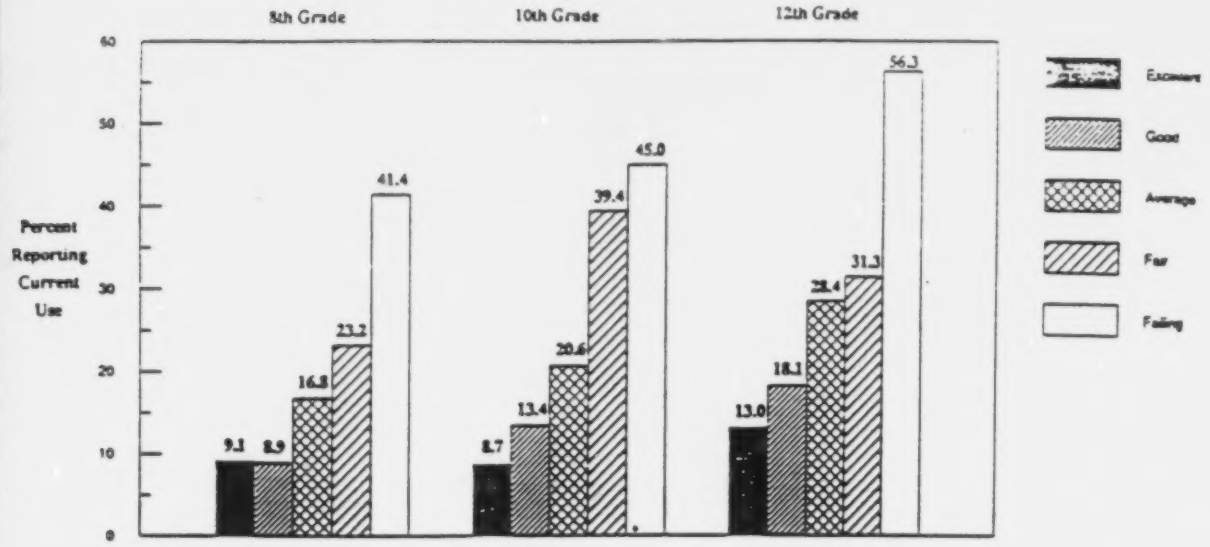
	8th Grade	10th Grade	12th Grade
Current Use of Any Drug*	13.0	18.5	22.3
Current Use of Any Substance**	7.2	47.7	58.4
Current Use of Alcohol	23.6	45.2	56.0
Current Use of Alcohol and any Drug	9.4	15.8	19.8
Mean Number of Drugs	2.3	2.4	2.2

* Excludes Alcohol, Cigarettes and Smokeless Tobacco

** Excludes Cigarettes and Smokeless Tobacco

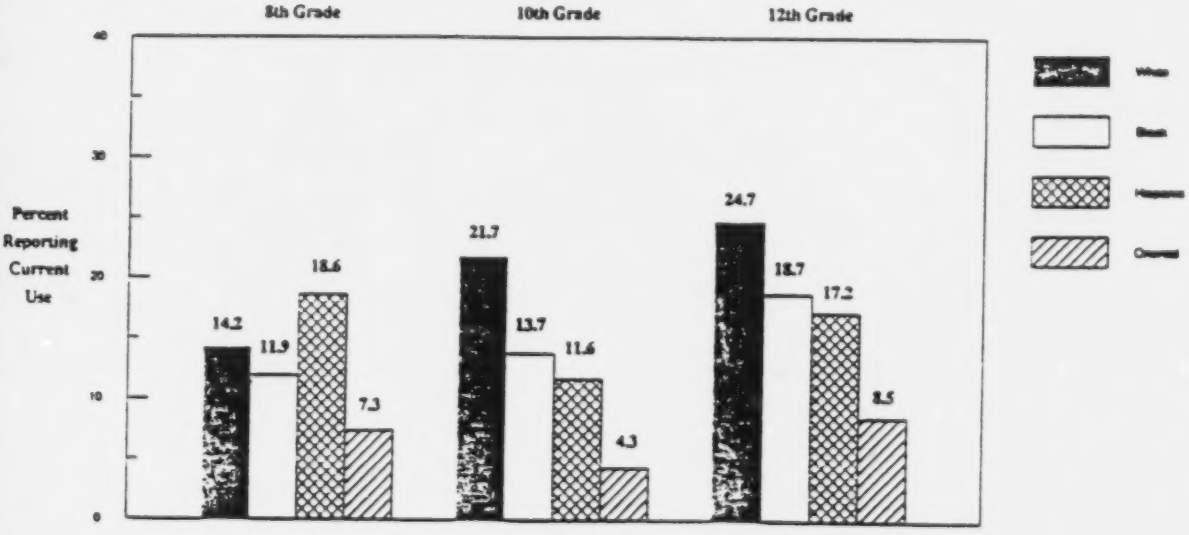
Slide 12

Percent of Maryland Adolescents Reporting Current Use
of Any Drug by Grade Last Year – 1986-87 Survey



Slide 13

Percent of Maryland Adolescents Reporting Current Use
of Any Drug by Race/Ethnicity – 1986-87 Survey



Slide 14

Percent of 12th Graders Nationwide[1] And In Maryland
Reporting Current Use[2] of Substances in 1982-83, 1984-85, and 1986 -87

	Nationwide			Maryland		
Substance	1982-83	1984-85	1986-87	1982-83	1984-85	1986-87
Marijuana	28.5	25.2	23.4	33.9	30.0	17.1
Tranquilizers	2.4	2.1	2.1	8.7	6.4	1.8
Amphetamines	10.7	8.3	5.5	13.7	9.8	5.4
Cigarettes	30.0	29.3	29.6	31.7	29.2	23.6
Heroin	0.2	0.3	0.2	3.2	3.2	0.9
Cocaine	5.0	5.8	6.2	10.3	10.7	5.0
Hallucinogens	3.4	2.6	2.5	7.7	5.7	3.0
Barbiturates	2.0	1.7	1.8	7.4	5.4	1.2
PCP	1.0	1.6	1.3	4.7	5.7	3.0

1 Institute for Social Research, University of Michigan, News Release, February 23, 1987.
2 Current use in the national study is defined as used at least once in the 30 days prior to the survey.

Slide 15

SUBSTANCE ABUSE PREVALENCE SUMMARY

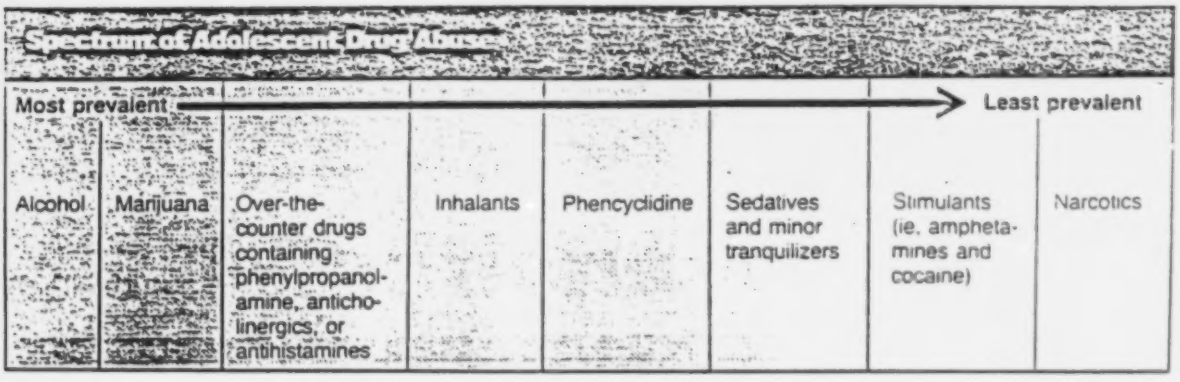
OF TWENTY-THREE MILLION TEENAGERS 12-17 YEARS OLD:

6.2 Million Currently Use Alcohol

3.5 Million Smoke Cigarettes

2.8 Million Currently Smoke Marijuana

Slide 16



Slide 17

STAGE 1: EXPERIMENTATION/LEARNING THE MOOD SWING

Characteristics	Behavior
°Infrequent Use	°Learning the Mood
°Alcohol/Pot	°Feels Good
°No Consequences	°Reinforcement
°Low Tolerance	°Return to Normal
°Fear of Use	

Slide 18

STAGE 2: SEEKING THE MOOD SWING

Characteristics	Behavior
°Increasing Frequency	°Use to Get High
°Use of Various Drugs	°Use on Weekdays
°Minimal Defensiveness	°Use to Relieve Feelings
°Tolerance	°Denial of Problem

Slide 19

STAGE 3: PREOCCUPATION WITH THE MOOD SWING

Characteristics

- Change in Peer Group
- Few Straight Friends
- Activities Tied to Use
- Steady Supply
- Consequences Frequent

Slide 20

STAGE 3: PREOCCUPATION WITH THE MOOD SWING

Behavior

- Begins to Violate Values and Rules
- Use Before and During School
- Use Despite Consequences
- Solitary Use
- Trouble with School
- Overdoses, "Bad Trips", Blackouts
- Promises to Cut Down/Attempts to Quit
- Protection of Supply
- Hiding Use from Peers
- Deterioration in Physical Condition

Slide 21

STAGE 4: USING TO FEEL NORMAL

Characteristics	Behavior
• Continued Use Despite Adverse Outcome	• Daily Use
• Loss of Control	• Failure to Meet Expectations
• Inability to Stop	• Loss of Control
• Compulsion	• Paranoia
	• Suicide Gestures
	• Physical Deterioration

Slide 22

RISK FACTORS FOR DRUG ABUSE

Family History of Alcoholism
Family Tolerance for Deviance
Depression
Loss of Loved One
Low Self-Esteem
Poor Social Skills
School Problems
Low Expectations for School
Peer Tolerance for Deviance

Slide 23

DRUG ABUSE WARNING SIGNS

BEHAVIORAL CHANGES
- Lying, Stealing
- Loss of Interest in Hobbies

SCHOOL CHANGES
- Fall Off in School Performance
- Conflicts at School
- School Truancy
  - Misses 1st Period Class
  - Class After Lunch
  - Last Class

EMOTIONAL CHANGE
- Depression
- Loss of Loved One

DEVIANCY
- Driving While Intoxicated
- Vandalism, B & E, Shoplifting

Slide 24

SUBSTANCE ABUSE SCREENING

Predisposing Risk Factors

Problems in Major Life Areas

Peer Use Characteristics

Personal Use Characteristics

Slide 25

TAKING A DRUG HISTORY FROM TEENAGERS

What kinds of drugs are at your school?
What kinds of drugs have friends tried?
What drugs have you tried?
Extent and regularity of use?
Where are drugs used?
Degree of use?
Degree of intoxication and risks associated with use?

MASTERS OF HANDOUTS

[Except for Handout 1, use materials from Teaching Activity 1]

SESSION OBJECTIVES

After participating in this session, participants will be able to:

- better understand the magnitude of alcohol and other drug problems within the pediatric population and recognize then as important health problems in children, adolescents and adults
- explain the natural history of substance abuse and the characteristics and family dynamics related to each of the four stages of use
- recognize substance abuse as a progressive illness

EQUIPMENT AND MATERIALS

_____ Slide projector

_____ Screen

_____ Microphone (optional)

_____ Podium (optional)

_____ Slides

_____ Student Handouts

SUGGESTED PREPARATION ACTIVITIES

____ Assign required readings

____ Advertise session if it is not required

____ Make slides for presentation

____ Familiarize self with all slides and handouts

____ Review articles on conducting lectures and group discussions (Gabel reference)

____ Develop student packets (contains all handouts, including objectives, recommended reading lists, and evaluation)

____ Develop evaluation form

____ Assess the needs, knowledge level, perceptions and related practice behaviors of the audience

____ Develop list of treatment resources available within the institution or community (refer to handout 5 as a proposed outline for such a list)

____ Determine need for audio-visual equipment

MODULE II: CURRENT DRUGS OF ABUSE

TITLE

CURRENT DRUGS OF ABUSE

FORMAT(S)

Lecture
Small Group Discussion

SESSION GUIDELINES

Time:	1-2 hours
Prerequisites:	None
Space Recommendations:	None
Suggested Number of Participants:	15-40

OBJECTIVES

After participating in this session, participants will be able to:

- identify common drugs of abuse
- outline common behavioral and physiological effects and side effects for each common drug of abuse
- describe the basic characteristics of abuse, dependence and withdrawal
- outline the clinical presentation of acute intoxication and its adverse reactions for common drug of abuse

RELATED CURRICULUM GOAL(S)

II. To promote familiarity with common drugs of abuse.

SYNOPSIS

The intent of this session is to familiarize the learners with the common drugs of abuse. In concert with this and with the role of the primary care pediatrician, the session is not intended to be an in-depth study of the pharmacology of various drugs. Moreover, it is not intended to instruct participants in the management of acute medical emergencies. Instead, it is primarily to provide for participants a framework that will allow them to compare and contrast common drugs of abuse. Therefore, the focus of this session is to identify commonalities and differences among several drugs of abuse.

INSTRUCTOR'S RESOURCES

Jaffe JH: Drug addiction and drug abuse In Gilman AG and Goodman LS (eds): The pharmacologic basis of therapeutics, 7th edition. MacMillam, New York, 1985; 532-581.

Giannini AJ, Price WA et al: Contemporary drugs of abuse. American Family Physician 1986; 33(3): 207-216.

Editorial: Diagnosis and management of acute drug abuse reactions. The Medical Letter 1983; 25(644): 85-88.

Kulberg A: Substance abuse: Clinical identification and management. Ped C of N Amer 1986; 33(2): 325-361.

Clouet DH (ed): Phencyclidine: An update. U.S. Government Printing Office DHHS publication no. (ADM)86-1443, Washington, D.C., 1986.

Schwartz RH: Marijuana: An overview. Ped C of N Amer 1987; 34:305.

SESSION OUTLINE

Introduction	TT: 5 MIN	RT: 5 MIN

Introduction of Presenter(s) and Participants

Review Purpose and Goals of Session [Handout 1]

Establish Ground Rule for Session

Review Materials

Lecture and Discussion	TT: 90	RT: 95
	[approximately 10 min for each drug]	

A. Common Drugs of Abuse

1. Alcohol [Instructor's Material 1]
2. Marijuana [Instructor's Material 2]
3. Amphetamines/CNS Stimulants [Instructor's Material 3]
4. Cocaine [Instructor's Material 4]
5. CNS Depressants/Sedative Hypnotics [Instructor's Material 5]
6. Hallucinogens [Instructor's Material 6]
7. Phencyclidine (PCP) [Instructor's Material 7]
8. Volatile Inhalants [Instructor's Material 8]
9. Heroin/Opiates [Instructor's Material 9]

B. Content Areas (for each drug)

1. Generic & Trade Names
2. Street Names
3. General Information
4. Methods of Use
5. Formulation/Paraphernalia
6. Clinical Manifestations
7. Treatment of Acute Intoxication

Evaluation (Optional)	TT: 5 MIN	RT:100 MIN

Distribute evaluation and ask participants to complete

Summary and Closure	TT: 5 MIN	RT:105 MIN

Refer back to objectives to determine if they were successfully completed. Summarize with group. [Handout 1]

INSTRUCTOR'S MATERIALS

IM 1 - Alcohol

IM 2 - Marijuana

IM 3 - Amphetamines/CNS Stimulants

IM 4 - Cocaine

IM 5 - CNS Depressants/Sedative Hypnotics

IM 6 - Hallucinogens

IM 7 - Phencyclidine (PCP)

IM 8 - Volatile Inhalants

IM 9 - Heroin/Opiates

The following Learner's Materials are also to be used by the instructor:

Handout 1 - Session Objectives

Alcohol

Generic & Trade Names: Ethyl Alcohol

Street Names: Booze, brew, juice, beer, grog, coolers

General: Alcohol is the most common drug of abuse. Over 90% of high school seniors report having used alcohol at some point in their lives. 85% report use in the past year and 65% report use in the past most. Almost one half of males and one third of female seniors report episodes of binge drinking within the past two weeks defined by five or more drinks in a row.

How It's Used: Ingested orally

Clinical Manifestations

mental status: aggressive; belligerent behavior; impaired mentation; sleepiness; slurred speech

physical examination: ataxia, constricted pupils, hypertension, hypothermia; respiratory depression; arrhythmias; (look for signs of associated trauma, aspiration)

withdrawal syndrome: anxiety; insomnia; irritability. Severe withdrawal (convulsions, delirium, hallucinations) is rarely seen in adolescents.

Treatment of Acute Intoxication: supportive care and correction of metabolic abnormalities (hypoglycemia, acidosis)

Marijuana

Generic & Trade Names: Marijuana derivatives, Hashish or "Hash", THC

Street Names: Acapulco Gold, Cannabis, Ganja, Grass, Herb, Hemp, J. Joint, Mary Jane, Pot, Reefer, Roach, Sativa, Sinsemilla, Smoke, Thai Sticks, Weed

General: Marijuana produces a dreamy state in which ideas seem to flow freely and perceptions appear to be deeper, clearer and more intense. The marijuana smoker seeks a feeling of inner peace, joy and well-being, known as a high. Of high school seniors in 1986, over half have tried it, almost one-fourth use the drug at least once a month and 4% smoke it every day.

How It's Used: Generally, the dried marijuana leaves and buds are rolled in cigarette papers to form joints that are then smoked. Depending on the strength of the pot, one joint or less is what's needed to get "high." Pipes, usually with small bowls, can also be used. In either case, the smoke is inhaled and held in the lungs much longer than regular cigarette smoke.

User Characteristics: Regular pot smokers often look and function normally. However, the inexperienced or infrequent user will seem relaxed and happy, and talk more slowly than usual. Thought patterns may seem slightly disjointed. Behavior may seem less inhibited.

Formulation/Paraphernalia: Marijuana is often kept in plastic bags. It has a striking resemblance to the herb oregano, although stems and seeds are frequently present. Rolling papers or pipes are frequently used for smoking marijuana. Small matchboxes and other small containers (such as 35mm film canisters) may be used for joints, roaches (the remains of smoked joints) or loose marijuana.

Clinical Manifestations

mental status: anxiety, anorexia, increased appetite, confusion, depersonalization, dream-like fantasy state, euphoria, excitement, hallucination, panic reactions, time-space distortions

physical examination: ataxia , dry hacking cough, injected conjunctiva, postural hypotension, tachycardia

withdrawal syndrome: anorexia, anxiety, depression, insomnia, irritability, nausea, restlessness. Acute withdrawal reactions are rare.

Treatment of Acute Intoxication: no specific treatment is indicated. Diazepam may be used for severe anxiety or panic reactions.

Amphetamines/CNS Stimulants

Generic & Trade Names: Metha-amphetamines, dextro-amphetamines and similar products such as Preludin

Street Names: Bennies, Black Beauties, Coast to Coasts, Copilots, Crystal Meth, Dexies, Lid Poppers, Meth, Pep Pills, Roses, Speed, Thrusters, Truck Drivers, Uppers, Wake Ups, Whites

General: Amphetamines are drugs that affect the central nervous system. They increase alertness, relieve fatigue, delay the need for sleep and suppress appetite (hence their use for weight control). They are commonly taken for the euphoric feelings they produce and the sense of enhanced physical and mental capacities. 13% of high school seniors report using these drugs once a month.

How It's Used: Amphetamines can be taken orally, snorted or injected.

User Characteristics: Depending on the dose, the amphetamine user may appear nervous, very active and very talkative. Loss of appetite, long periods of sleeplessness (frequently followed by long periods of sleep) and heavy sweating are also common. The user's eyes will seem bright and shiny, and the pupils will be dilated. Weight loss and chain-smoking are common among chronic abusers.

Formulation/Paraphernalia: Amphetamine users will have pills and capsules of various shapes, sizes and colors. Heavy speed users may eventually inject the chemicals.

Clinical Manifestations

mental status: agitation; anxiety; decreased appetite; decreased sleep; delirium; hallucinations; hyperactivity; hyperacute or confused sensorium; impulsivity; paranoid ideation; restlessness

physical examination: arrhythmia; blurred vision; coma; convulsions; dilated pupils; dry mouth; hyperreflexia; hypertension; hyperthermia; hyperventilation; stroke; sweating; tachycardia; tremors

withdrawal syndrome: anxiety; chills; depression; exhaustion; muscular aches; sleep disturbances; depression; tremors; voracious appetite

Treatment of Acute Intoxication: supportive care, "talk patient down"; haloperidol for aggressiveness, agitation and hallucinations; diazepam for control of agitation and seizures; forced diuresis and acidification of urine. After patient has "crashed: a mild antidepressant (i.e. nortriptyline) can be given.

Cocaine

Street Names: Blow, The Big C, Coke, Flake, Girl, Heaven Dust, Lady, Nose Candy, Paradise, Rock, Snow, Snuff, Toot, White

General: Cocaine, a white, crystalline powder, produces a rapid, but short-lived high. It increases energy, causes rapid heartbeat and heightens perceptions. Cocaine has the reputation of being a socially prestigious drug. While it was once the drug of the wealthy, cocaine now pervades all strata of society. Increased availability and affordability, a false perception of safety with occasional use, the association with persons in glamourous occupations, the reputation of being a sexually enhancing drug and peer pressure all contribute to its increased use. 17% of high school seniors in 1986 reported using it at least once.

How It's Used: Cocaine is generally snorted. It can also be injected or smoked as a free base.

User Characteristics: Occasional small volume cocaine use, especially by the intranasal route, may be difficult to detect. The patient with occasional use may have a history of prior tobacco and marijuana use. The family may have noted short-lived mood swings and personality changes. Regular intermittent use may be associated with loss of interest in usual activities, new friends, and chronic lack of money or evidence of stealing. Upper respiratory symptoms, nasal congestion or persistent rhinorrhea (often attributed to a "cold" or allergic rhinorrhea) may be present. Chronic long term use may be associated with anxiety, depression, paranoia, and withdrawal from family and friends. Frequently, marijuana, sedatives or alcohol are used to counteract the effects of the cocaine. Physical symptoms may be exacerbated. Severe paranoia and depression can lead to harm to self or others.

Formulation/Paraphernalia: With razor blades on pieces of mirror or glass, cocaine users "cut", or portion out, the drug. They also use small spoons, straws and/or rolled dollar bills to hold the white crystalline powder as they snort it. Heavy users may inject cocaine, so needles may be a sign of use. Crack cocaine is often bought as chips or flakes and kept in small vials or other containers.

Clinical Manifestations

mental status: agitation; hallucinations; panic; paranoia; psychosis; mood elevation; increased concentration

physical examination: euphoria; arrhythmia; coma; convulsions; dilated pupils; hyperpnea; hyperreflexia; hypertension; hyperthermia; myocardial infarction; respiratory failure; sweating; stroke; tachycardia; nose bleeds.

withdrawal syndrome: depression; irritability

Treatment Of Acute Intoxication: Support of ventilation; IM haloperidol, 5 mg q/h until improved for psychotic behavior; IV diazepam for seizures; cooling blanket for hyperthermia. Hypertension is best treated with a vasodilator such as nifedipine. Propranolol, purported to be an antidote for cocaine intoxication, is best reserved for tachycardia only. Use of beta-blocking agents in the face of elevated levels of norepinephrine may result in unopposed alpha-receptor stimulation; this can paradoxically worsen hypertension.

CNS Depressants/Sedative Hypnotics

Generic & Trade Names: Benzodiazepines, Amytal, Seconal, Tuinal, and Methaqualones (Quaaludes)

Street Names: Barbs, Blue Devils, Double Trouble, Downers, Goof Balls, Nebbies, Phennies, Pink Ladies, Rainbows, Reds, Red Devils, Sleeping Pills, Solid Booze, Stumblers, Yellow Jackets, Yellows, Ludes, Quads, Sopers, 714's.

General: Barbiturates and methaqualones, also known as depressants, are generally prescribed for their calming and sleep-inducing effects. They affect the central nervous system by slowing down breathing, the heart rate and thinking. Users claim feelings of elation, tranquility and well-being when taking these drugs. 2 % of high school seniors report using these drugs at least once in the past month. Some people take Quaaludes because they think it's an aphrodisiac.

How It's Used: Depressants are usually taken orally, but they can be injected

User Characteristics: Depressants have a calming effect, causing an intoxication similar to that of alcohol. Speech may be slurred, judgment impaired and the user may exhibit ataxia. Heavy users feel extremely tired and may fall asleep at inappropriate times. They exhibit confusion and increased sweating. As doses increase, shallow respiration and a weak but rapid pulse ensue. Overdoses may lead to convulsions and death.

Formulation/Paraphernalia: Depressants are almost always found in pill or capsule form. The shape, size and color may vary. Heavy users may eventually inject the drug.

Clinical Manifestations:

mental status: coma, confusion, delirium, disorientation, drowsiness, slurred speech

physical examination: ataxia, convulsions (methaqualone), hyperreflexia, hypotension, hypothermia, hypotonia, nystagmus, pulmonary edema, respiratory depression

withdrawal syndrome: agitation, anxiety, arrhythmias, seizures, delirium, disorientation, fever, hallucinations, hyperreflexia, hypertension, insomnia, irritability, sweating, tremors, weakness, cardiovascular collapse

Treatment of Acute Intoxication: supportive care, maintain airway and ventilation,support BP, forced diuresis, alkalinization of urine, hemodialysis may be indicated with high blood levels of long-acting agents. Acute withdrawal can be life-threatening. the dosage may need to be tapered, or phenobarbital or pentobarbital substituted and the dosage gradually decreased.

Hallucinogens

Generic & Trade Names: (LSD) Lysergic Acid Diethylamide, Mescaline, Morning Glory Seeds, Nutmeg, Psilocybin

Street Name: LSD "acid, blotters, cubes, lucy in the sky with diamonds, microdots, sugar, windowpane"; Mescaline "button, moon"; Morning glory seeds "heavenly gates, flying saucers, licorice drops"; Nutmeg "brown slime; Psilocybin "shrooms".

General: Hallucinogens are drugs that not only affect the central nervous system, but distort objective reality. LSD and other hallucinogens confuse the user's sense of direction, alter perceptions of time and distance, and impair judgment. Sounds can reportedly be "seen" and sights "heard." 10% of high school seniors have tried hallucinogens.

The "desired" effects of hallucinogens are generally described as "dreamlike trips", but the drug can also lead to dangerous behavior.

How It's Used: LSD and most other hallucinogens (like PCP, DMT Mescaline, STP and Psilocybin) are usually taken by mouth. Sugar cubes or blotter papers containing LSD can be licked or sucked.

User Characteristics: LSD and other hallucinogens are mood-altering drugs that can result in dramatic changes of behavior. Look for a dazed appearance and rambling speech. There will be significant distortions of space, time and judgment. During a "trip" which can last up to 8 hours, users sometimes seem panicky or extremely anxious. Following the "trip", the users are most likely to get drowsy and sleep.

Formulation/Paraphernalia: LSD can be found in many forms. Powders, liquids and capsules are common. It is also soaked onto sugar cubes, postage stamps and small pieces of paper.

Clinical Manifestations

mental status: anxiety, confusion, seizures, depersonalization, hallucinations, illusions inappropriate affect, panic, paranoia, synesthesia, time and visual distortions.

physical examination: dilated pupils, hyperreflexia, hypertension, hyperthermia, tachycardia, tremors,

withdrawal syndrome: none

Treatment of Acute Intoxication: (supportive care, psychologic support ("talking down" in a quiet room), IM haloperidol for severe agitation, IV diazepam for sedation, cooling blanket for hypothermia. Avoid antipsychotic drugs.

Phencyclidine (PCP)

Generic & Trade Names: Phencyclidine

Street Names: Angel Dust, Crystal, Hog, Horse Tranquilizer, Killer Weed, Supergrass, THC, Tic Tac

General: PCP, an anesthetic used by veterinarians, is a hallucinogenic drug. It not only affects the central nervous system, but cause perceptual distortions as well. PCP can alter moods, confuse the user's sense of direction and cause the imagination to roam. Experiences while taking PCP can be dreamlike or nightmarish. 5% of high school seniors have reported trying PCP.

How It's Used: PCP can be swallowed or inhaled, but is usually sprinkled over parsley flakes or marijuana and smoked.

User Characteristics: PCP causes dramatic changes in behavior, disoriented appearance, rambling speech, anxiety and panic. PCP is apt to leave the user laughing and more confused than LSD or other psychedelics. PCP has reportedly led to violent and aggressive behavior. After a "trip", the user will most likely get drowsy and sleep.

Formulation/Paraphernalia: PCP can be found in many forms, powder, liquid or capsule, but is often sprinkled on parsley flakes or marijuana.

Clinical manifestations

mental status: amnesia; anxiety; coma; convulsions; excitement; hallucinations; hyperactivity; impulsive, self-destructive or violent behavior; mutism; stupor; psychosis

physical examination: ataxia; drooling; dysrhythmia; flushing; hypertension; hyperthermia; hyperreflexia; myoclonus; nystagmus, particularly vertical; open-eyed coma; tachycardia

withdrawal syndrome: none

Treatment of Acute Intoxication: psychological support; observation in a quiet area (do not attempt to "talk down"); IV diazepam for sedation and convulsions; haloperidol, 5 mg IM every 20 minutes until improved, for severe agitation; forced diuresis and acidification of urine; protect from harm; propranolol for dysrhythmia.

Volatile Inhalants

Generic & Trade Names: Aliphatic and aromatic hydrocarbons (gasoline, toluene, benzene, xylene), halogenated hydrocarbons (freons, halothane, trichlorethylene), aliphatic nitrites (amyl, n-butyl and isobutyl nitrate), nitrous oxide

Street Names: Glue, correction fluid, gas, paint thinner and removers, aerosol propellants, Rush, Bolt, laughing gas, locker room

General: Inhalants are frequently the first mood altering substance used by children. They are popular because of their rapid onset of action, quality and pattern of the "high", low cost, easy availability, convenient packaging and the fact that possession is not illegal in most states. Most of these substances are readily available on the open market. Six percent of high school seniors in 1986 reported use of one of these substances in the past year and 16% at some point in their lives.

How It's Used : Inhalation of these various liquids and aerosol sprays

Clinical Symptoms

mental status: confusion, convulsions, disorientation, dizziness, euphoria, hallucination, headache, impulsive behavior, psychosis, somnolence, stupor

physical examination: arrhythmias, ataxia, coughing, drooling, hyperreflexia, hypotension, peripheral neuropathy, sneezing, tachycardia, nausea, flushing

Withdrawal Syndrome: none

Treatment of Acute Intoxication: supportive, maintenance of adequate ventilation

Heroin/Opiates

Street Names: Big H, Brown Sugar, Crap, H, Horse, Junk, Scag, Smack, Stuff

General: Heroin, an opiate narcotic, produces a euphoric high, while eliminating bodily aches and pains. When first injected, heroin cause a warm sensation of the skin and a feeling likened to sexual orgasm. This sensation, called a rush, is followed by a dreamy high. As the user's body becomes accustomed to the drug, it takes more and more of the drug to produce the same high. Heroin is rarely used by high school seniors. Only 0.5% of seniors in 1986 reported any use in their lifetime. However, 5.2% of seniors reported use of other opiates.

How It's Used: Heroin is generally injected into a vein in the arm. It is occasionally snorted, or injected under the skin (called "skin popping").

User Characteristics: Chronic heroin users may have scars, known as "tracks", on their bodies, especially their arms. While under the influence they will scratch themselves frequently and alternately doze and awaken. They seem lethargic and their pupils are constricted. Users may appear anxious, have poor coordination and slurred speech. They may also appear perfectly normal.

Formulation/Paraphernalia: The "works" required for heroin injection include: syringes, metal bottle caps, bent spoons, matches, medicine droppers, a tourniquet (such as string, rope, a belt), cotton and glassine bags. The bottle caps and spoons will often have burn marks.

Clinical Manifestations

mental status: euphoria; stupor

physical examination: coma; constricted pupils; convulsions; hyperreflexia; hypotension; hypothermia, hypoventilation; pulmonary edema

withdrawal syndrome: myalgias; anxiety; diarrhea; dilated pupils; gooseflesh; lacrimation; muscle jerks; tachycardia; tremulousness; vomiting; yawning

Treatment of Acute Intoxication: IV or IM naloxone, 0.4-2 mg initially followed by continuous IV infusion of 2/3 of total initial dose Q 1H; positive end-expiratory pressure for pulmonary edema. Withdrawal can be treated in a number of different ways. Withdrawal is generally not life threatening. The withdrawal syndrome can be blunted by the use of oral clonidine, but it can cause hypotension.

EVALUATION FORM

1.	How would you describe your knowledge of substance abuse treatment modalities:	less than adequate	adequate	more than adequate
	a. prior to the session?	1	2	3
	b. after the session?	1	2	3
2.	How helpful was the case study in each of the following:	not very helpful	helpful	very helpful
	a. illustrating the progressive nature of addiction?	1	2	3
	b. providing discussion points around the role of the physician?	1	2	3
3.	How likely is it that you would refer a patient to treatment in the following circumstances:	very unlikely	likely	very likely
	a. if a parent requested such for his/her adolescent who you thought was chemically dependent?	1	2	3
	b. for a chemically dependent adolescent whose parent(s) are ambivalent or even unaware of a problem?	1	2	3
	c. for a patient's parent who you knew had a chemical dependency?	1	2	3

4. What was most helpful to you in today's presentation?

_____

_____

_____

5. What was least helpful or what changes would you recommend?

_____

_____

THANK YOU

SESSION OBJECTIVES

After participating in this session, participants will be able to:

- identify common drugs of abuse
- outline common behavioral and physiological effects and side effects for each common drug of abuse
- describe the basic characteristics of abuse, dependence and withdrawal
- outline the clinical presentation of acute intoxication and its adverse reactions for common drug of abuse

EQUIPMENT

Slide projector (optional)

Slides (optional)

SUGGESTED PREPARATION ACTIVITIES

_____ Assign required readings

_____ Review all instructor and learner material

_____ Develop student packets

_____ Consider whether to use slides or other audio-visual aids as part of the lecture

_____ Develop and make copies of an evaluation form if needed

_____ Assess needs, knowledge level, perceptions and related practice behaviors of participants

_____ Familiarize self with the prevalence of specific drugs in your area

TITLE

SUBSTANCE ABUSE INTERVIEWING

FORMAT(S)

Lecture
Video Presentation
Role Playing
Group Discussion

SESSION GUIDELINES

Time:	2 Hours
Prerequisites:	None (although Module 1 is suggested)
Space Recommendations:	Need enough room to divide participants into diads or triads to do role plays
Suggested Number of Participants:	15

OBJECTIVES

After participating in this session, participants will be able to:

- review the four phases of the substance abuse interview: transition, screening, data feedback, and closure
- state the questions to be asked to elicit substance use information
- utilize screening questions, such as the CAGE, and other mnemonic devices, such as PACES and HEADS, to aid in the organization of data collection and assessment
- review and practice interviewing skills that improve the acquisition of relevant information
- take the first steps in developing the skills necessary for effective substance use interviewing

RELATED CURRICULUM GOAL(S)

I. To increase awareness of general concepts of substance abuse

IV. To provide basic skills to effectively intervene and engage the patient and family into treatment

SYNOPSIS

This session uses a number of instructional formats to teach participants effective interviewing skills. The majority of the session is devoted to role plays in which all participants should take part. The premise of this session is that physicians will be more inclined to ask difficult substance use related questions if they first had the opportunity to practice these questions in a safe, non-judgmental setting.

INSTRUCTOR'S RESOURCES

Anglin TM. Interviewing guidelines for clinical evaluation of adolescent substance abuse. Ped C N Amer 34(2):381, 1987.

Block MR, Coulehan JL. Teaching the difficult interview in a required course on medical interviewing. J Med Educ 62(1):35-40. 1987 Jan (87086703)

Blum R. Physicians' assessment of deficiencies and desire for training in adolescent care. J Med Educ 62(5):401, 1987.

Cavanaugh RM Jr. Obtaining a personal and confidential history from adolescents. An opportunity for prevention. J Adol Health Care 7(2):118-22 1986 Mar (86167704)

Felice M, Friedman SB. Behavioral Considerations in the Health Care of Adolescents. Ped C N Amer 29:399, 1982.

Gallagher JR. Interviewing Adolescents and Their Parents. J Current Adol Med 1:15, 1979.

Kastner LS, Marcuse EK, McGuire TL, Rothenberg MB. A method for the teaching of interviewing skills. Amer J Dis Child 139(9):899-902. 1985 Sep (85304092)

Korsch BM, Gozzi EK, Francis V. Gaps in Doctor Patient Communication. Pediatrics 42:855, 1968.

Lipkin M, Quill TE, Napodano R. The Medical Interview: A core curriculum for residencies in Internal Medicine. Annals of Int Med 100:277, 1984.

Menahem S. Interviewing and examination skills in paediatric medicine: videotape analysis of student and consultant performance. J R Soc Med 80(3):138-42 1987 Mar (87198555)

Mumford E, Anderson, Cuerden T, Scully J. Performance-Based Evaluation of Medical Students' Interviewing Skills. J Med Educ 59:133, 1984.

Neinstein LS. The Office Visit and Interview Techniques in Neinstein Adolescent Health Care, Baltimore, Urban & Schwarzenberg, 1984.

Silber TJ. Approaching the adolescent patient. Pitfalls and solutions. J Adol Health Care 7(6):31S-40S 1986 Nov (87056615)

Slap GB. Adolescent medicine: attitudes and skills of pediatric and medical residents. Pediatrics 74(2):191-7. 1984 Aug (84272056)

Stillman PL, Burpeace-DiGregorio MY, Nicholson GI, Sabers DL, Stillman AE. Six Years of Experience Using Patient Instructors to Teach Interviewing. J Med Educ 58:941, 1983.

Stillman PL, Falginiti VA, Rousseau E, Sabers DL. Results of a Survey of Pediatric Clerkship Programs in American Medical Schools. Am J Dis Child 135:348, 1981.

Werner A, Schneider JM. Teaching Medical Students Interactional Skills: A research based course in the doctor-patient relationship. NEJM 290:1232, 1974.

SESSION OUTLINE

Introduction	TT: 5 MIN	RT: 5 MIN

Introduction of Presenter(s) and Participants

Review Purpose and Goals of Session [Handout 1]

Establish Ground Rules for Session

Review Materials

Lecture	TT: 15 MIN	RT: 20 MIN

Key Concepts of Substance Abuse Interviewing

A. Four Phases of an Interview [Handout 2]

B. Principles of Substance Abuse Interviewing [Handout 3]

C. Guidelines for Substance Abuse Interviewing [Handout 4]

Videotape Presentation	TT: 15 MIN	RT: 35 MIN

Present videotape to group

Discuss the videotaped interview

Discuss the CAGE questions [Handout 5]

Role Plays	TT: 60 MIN	RT: 95 MIN

Conduct a simulated interview to role play for the participants

Review Observation Checklist with Participants [Handout 7]

Arrange groups into groups of three or four (depending on size) with one person playing patient, one physician, and one observer.

Conduct Interview Scenario 1 [Handout 6]
Instruct participants to switch roles so everyone has a chance to ask questions.

Discuss role play 1

Continue the process for each scenario making sure to discuss each one (May consider having one or two groups present a role play in front of the group)

Evaluation (Optional) TT: 5 MIN RT:100 MIN

Distribute evaluations and ask participants to complete [Handout 8]

Summary and Closure TT: 10 MIN RT:110 MIN

Refer back to objectives to determine if they were successfully completed. Summarize session with group. [Handout 1]

INSTRUCTOR'S MATERIALS

The Medical Interview Video (only the portion that is specific to the CAGE questions)

The following learner's materials are also to be used by the instructor:

Handout 1 - Session Objectives

Handout 2 - Four Phases of the Substance Abuse Interview

Handout 3 - Principles of Substance Abuse Interviewing

Handout 4 - Guidelines for Substance Abuse Interviewing

Handout 5 - The C.A.G.E. and Follow-Up Questions

Handout 6 - Interview Scenarios

Handout 7 - Observation Checklist

Handout 8 - Session Evaluation

Handout 9 - References

SESSION OBJECTIVES

After participating in this session, participants will be able to:

- review the four phases of the substance abuse interview: transition, screening, data feedback, and closure
- state the questions to be asked to elicit substance use information
- utilize screening questions, such as the CAGE, and other mnemonic devices, such as PACES and HEADS, to aid in the organization of data collection and assessment
- review and practice interviewing skills that improve the acquisition of relevant information
- take the first steps in developing the skills necessary for effective substance use interviewing

FOUR PHASES OF THE SUBSTANCE ABUSE INTERVIEW

TRANSITION

For primary care pediatricians, the substance abuse interview is typically only a portion of the complete medical interview. Alcohol and/or drug questioning is most appropriate within the psychosocial portion of the interview, following queries into other issues such as use of caffeine or cigarettes. A smooth transition could be something such as..."I've just asked you about cigarette use, now I'd like to ask you about your use of alcohol...your use of drugs..."

SCREENING FOR DRUGS/ALCOHOL

C.A.G.E.
C - Have you ever felt the need to CUT down on your drinking?
A - Have you ever been ANNOYED by criticism of your drinking?
G - Have you ever felt GUILTY about your drinking?
E - Have you ever had a morning EYE-OPENER?

H.E.A.D.S.	P.A.C.E.S.	FOUR F's
H - home	P - parents, peers, pot	F - Family
E - education	A - alcohol	F - Friends
A - activities	C - cigarettes	F - Future
D - drugs	E - education	F - Fertility
S - sex	S - sex	

FEED BACK RELEVANT DATA

Rather than warning, threatening, labeling, moralizing, etc., the physician should listen emphatically to what the patient has to say and attempt to reflect it back. A person is more likely to integrate and accept that which is reached by his or her own reasoning process than something that is decided for him. Therefore, the physician reinforces the patient's statements of self-perceived problems related to drug or alcohol use.

CLOSURE

The goal here is to accurately summarize the physician/patient interaction thus far. Questions from the parent should be elicited and answered. Any directions should be reviewed. Finally, a follow-up plan, if necessary, should be discussed.

PRINCIPLES OF SUBSTANCE ABUSE INTERVIEWING

Remember there is no one correct way to interview patients, except for that which feels comfortable to you.

Interview both the adolescent and the parent(s) in private, and also together.

Be firm, direct, non-judgmental and non-defensive.

Use language familiar to the patient and avoid jargon.

Maintain focus on one topic at a time.

Ask open-ended questions to engage the individual.

Ask progressively focused questions.

Avoid asking leading questions.

Elicit information about the person's concern of their own or someone else's substance use.

Be prepared to share information and a rationale for needing certain pieces of information.

Make rules of the interaction explicit, use and explain the concept of contracting as a way to prepare the patient for more difficult questions.

Remember to pace the interview to allow exploration of relevant pieces of information.

Invite and answer questions.

Summarize for the patient when necessary.

If defense mechanisms arise in spite of skillful interviewing precautions, recognize these as protective strategies of the patient, acknowledge their existence, and proceed.

GUIDELINES FOR SUBSTANCE ABUSE INTERVIEWING

PROCEDURE	RATIONALE
Begin with discussion of more general life-style questions including the following topic areas: (1) home and family relationships (2) functioning at school (3) peer relationships (4) leisure activities and employment (5) self-perception	Allows time to develop or renew patient/physician relationship Provides basis (through general psychosocial information) to determine patient's risk for harmful involvement
Ask about dietary patterns	Start with least threatening questions
Proceed to questions about prescribed medications	Move to increasingly sensitive substances
Ask about over-the-counter-medications	Use of products to relieve symptoms of upper respiratory infections and and allergic rhinitis, indigestion remedies, analgesics, drugs to promote wakefulness, hypnotics, and topical eye drops are commonly used by substance abusing adolescents
Inquire about cigarette and smokeless tobacco use	This order of questioning provides a natural order of progression, moving from the socially accepted...
Learning about the use of alcohol is next in the interview	to the socially tolerated...
Question the adolescent about use of marijuana	to the socially disapproved...
Finally the interviewer should ask about the use of any illicit drugs	to the overtly illegal.

THE CAGE AND FOLLOW-UP QUESTIONS

1. Have you ever been concerned about your own or someone else's drinking?

   OR

   Have you ever felt the need to cut-down on drinking?

Probe: What was it like? Were you successful? Why did you decide to cut down?

2. Have you ever felt annoyed by criticism of your drinking?

Probe: What caused the worry or concern? Do you ever get irritated by their worry? Have you ever limited what you drink in order to please someone?

3. Have you ever felt guilty about your drinking?

   OR

   Have you ever felt guilty about something you said or did while you were drinking?

Probe: Have you ever been bothered by anything you have done or said while you've been drinking? Have you ever regretted anything that has happened to you while you were drinking?

4. Have you ever taken a morning eye opener?

Probe: Have you ever felt shaky or tremulous after a night of heavy drinking? What did you do to relieve the shakiness? Have you ever had trouble getting back to sleep early in the morning after a night of heavy drinking?

INTERVIEW SCENARIOS

SCENARIO 1
Physician

You are the physician seeing John, a 15 year old boy brought in by his parents. They are concerned because he seems to be sleeping more than usual, looks tired all the time, and has done less well in his school work. You have completed your initial history. You have concerns and are about to take a drug history.

SCENARIO 1
Patient

You are a 15 year old boy in the 10th grade. Your parents have brought you to see the doctor. They are concerned because you have been sleeping more than usual and you are less interested in your usual hobbies. Your school grades have dropped slightly. You have acquired many new friends in high school. Your parents don't know that you are smoking marijuana 4-5 days a week. You also drink alcohol 2-3 times per week. You broke your wrist after falling from your bicycle this summer; you were high at the time. Your parents can't stand your attitude anymore. You keep a "stash" under your mattress in your bedroom. All your friends also get high regularly.

You are willing to be honest about your alcohol use but not your drug use.

SCENARIO 2
Physician

You are seeing a 12 year old female for evaluation of headaches and abdominal pain. You have been unable to establish a cause for her symptoms. You decide to review areas of the history to see if there are any other clues to the etiology. (The possibility of sexual abuse has been ruled out.)

SCENARIO 2
Patient

You are a 12 year old female, the youngest in the family of four children. You have been seeing your doctor for evaluation of headaches and abdominal pain.

The following are things you have not yet shared with your doctor:
-your father is a heavy drinker
-over the past year his drinking behavior has become more embarrassing
-you are reluctant to have friends over
-you fear for your mother's safety because your father tends to become violent when intoxicated.

You are willing to be honest about your situation when asked

SCENARIO 3
Physician

You are the pediatrician seeing Mrs. Smith and her 12 month old daughter for a routine well care visit. An interval history and assessment by the nurse indicates normal progress. The child is beginning to walk and has a bruise on the left thigh from a fall.

SCENARIO 3
Patient's Mother

You are the mother of a 12 month old child visiting the pediatrician for a scheduled well child care visit. You are upset with your spouse. He has started drinking heavily again and recently received a DWI citation. Several days ago he fell with the baby while intoxicated. The baby has a bruise on her thigh from the incident.

SCENARIO 4
Physician

You are seeing Mrs. Smith and her one month old baby. She is breastfeeding and reports that things are a little rocky over this first month. On her screening history questionnaire, she has checked "yes" for cigarettes and alcohol.

SCENARIO 4
Patient's Mother

You are a 23 year old female visiting your pediatrician for the first time with your one month old infant. You grew up in a household with a father and mother who were alcoholics. You have been feeling somewhat depressed recently and have found that alcohol helps take the "edge" off.

You are willing to be honest about your situation.

OBSERVATION CHECKLIST

N = not done/not done completely, P = partially completed, C = completed

	SCENARIO1			SCENARIO2			SCENARIO3			COMMENTS
Transition										
a. Establishes role and prepares/ orients patient	n	p	c	n	p	c	n	p	c	
b. Attends to privacy/confidentiality	n	p	c	n	p	c	n	p	c	
c. Addresses patient appropriately	n	p	c	n	p	c	n	p	c	
Data Gathering										
a. Open-ended questions	n	p	c	n	p	c	n	p	c	
b. Assesses PACES/HEADS and CAGE or Use-Concern	n	p	c	n	p	c	n	p	c	
c. Pursues appropriate clues	n	p	c	n	p	c	n	p	c	
d. Probes	n	p	c	n	p	c	n	p	c	
e. Uses contracting when necessary	n	p	c	n	p	c	n	p	c	
Affective Skills										
Non-verbal Skills										
a. eye contact	n	p	c	n	p	c	n	p	c	
b. posture	n	p	c	n	p	c	n	p	c	
c. comfort level	n	p	c	n	p	c	n	p	c	
Interviewer's Response										
a. empathetic	n	p	c	n	p	c	n	p	c	
b. non-judgmental	n	p	c	n	p	c	n	p	c	
c. supportive	n	p	c	n	p	c	n	p	c	
d. non-defensive	n	p	c	n	p	c	n	p	c	
Organization										
a. maintains focus on one topic	n	p	c	n	p	c	n	p	c	
b. progressively focused questions	n	p	c	n	p	c	n	p	c	
c. smooth transition	n	p	c	n	p	c	n	p	c	
d. summarizes when necessary	n	p	c	n	p	c	n	p	c	
Effective Closure										
a. Feedback of relevant data	n	p	c	n	p	c	n	p	c	
b. Expresses concern	n	p	c	n	p	c	n	p	c	
c. Educate about natural course of alcohol and drug problems in youth and/or adults	n	p	c	n	p	c	n	p	c	

Comments:

EVALUATION FORM

For each question please circle the most appropriate answer.

1. Prior to the session, I would have described my level of comfort in interviewing patients about their alcohol and drug use as:

   1 = Very Uncomfortable
   2 = Uncomfortable
   3 = Comfortable
   4 = Very Comfortable

2. How effective were each of the following formats in affecting your learning about substance abuse interviewing:

   a). demonstration and videotape — 1 2 3 4 5 6 7 8 9 10 (not effective ... very effective)

   b). "round robin" practice session — 1 2 3 4 5 6 7 8 9 10 (not effective ... very effective)

   c). role playing triads — 1 2 3 4 5 6 7 8 9 10 (not effective ... very effective)

3. As a result of this presentation, I feel better able to interview patients and/or their parents about alcohol or drug use.

   1 = Strongly Disagree
   2 = Disagree
   3 = Agree
   4 = Strongly Agree

4. The demonstration and videotape were helpful in illustrating the phases of a substance abuse interview and effective interviewing skills.

   1 = Strongly Disagree
   2 = Disagree
   3 = Agree
   4 = Strongly Agree

5. The role playing exercises were helpful in determining how to approach substance abuse interviewing with patients and/or their parents, and in developing the questions to ask.

   1 = Strongly Disagree
   2 = Disagree
   3 = Agree
   4 = Strongly Agree

6. COMMENTS:

REFERENCES

Anglin TM. Interviewing guidelines for clinical evaluation of adolescent substance abuse. Ped C N Amer 34(2):381, 1987.

Block MR, Coulehan JL. Teaching the difficult interview in a required course on medical interviewing. J Med Educ 62(1):35-40. 1987 Jan (87086703)

Blum R. Physicians assessment of deficiencies and desire for training in adolescent care. J Med Educ 62(5):401, 1987.

Cavanaugh RM Jr. Obtaining a personal and confidential history from adolescents. An opportunity for prevention. J Adol Health Care 7(2):118-22 1986 Mar (86167704)

Felice M, Friedman SB. Behavioral Considerations in the Health Care of Adolescents. Ped C N Amer 29:399, 1982.

Gallagher JR. Interviewing Adolescents and Their Parents. J Current Adol Med 1:15, 1979.

Kastner LS, Marcuse EK, McGuire TL, Rothenberg MB. A method for the teaching of interviewing skills. Am J Dis Child 139(9):899-902. 1985 Sep (85304092)

Korsch BM, Gozzi EK, Francis V. Gaps in Doctor Patient Communication. Pediatrics 42:855, 1968.

Lipkin M, Quill TE, Napodano R. The Medical Interview: A core curriculum for residencies in Internal Medicine. Annals Int Med 100:277, 1984.

Menahem S. Interviewing and examination skills in paediatric medicine: videotape analysis of student and consultant performance. J R Soc Med 80(3):138-42 1987 Mar (87198555)

Mumford E, Anderson, Cuerden T, Scully J. Performance-Based Evaluation of Medical Students' Interviewing Skills. J Med Educ 59:133, 1984.

Neinstein LS. The Office Visit and Interview Techniques in Neinstein Adolescent Health Care, Baltimore, Urban & Schwarzenberg, 1984.

Silber TJ. Approaching the adolescent patient. Pitfalls and solutions. J Adol Health Care 7(6):31S-40S 1986 Nov (87056615)

Slap GB. Adolescent medicine: attitudes and skills of pediatric and medical residents. Pediatrics 74(2):191-7. 1984 Aug (84272056)

Stillman PL, Burpeace-DiGregorio MY, Nicholson GI, Sabers DL, Stillman AE. Six Years of Experience Using Patient Instructors to Teach Interviewing. J Med Educ 58:941, 1983.

Stillman PL, Falginiti VA, Rousseau E, Sabers DL. Results of a Survey of Pediatric Clerkship Programs in American Medical Schools. Am J Dis Child 135:348, 1981.

Werner A, Schneider JM. Teaching Medical Students Interactional Skills: A research based course in the doctor-patient relationship. NEJM 290:1232, 1974.

EQUIPMENT

Videotape "The Medical Interview" from The Task Force on The Medical Interview and Related Skills of the Society for Research and Education in Primary Care Internal Medicine c/o Michael P. Simon, Ed.D., Primary Care Center, ACC 3S-14, Boston City Hospital, 818 Harrison Avenue, Boston, MA. 02118 (617) 424-5976.

Video Cassette Player

Monitor

SUGGESTED PREPARATION ACTIVITIES

_____ Get video "The Medical Interview"

_____ Arrange for audiovisual equipment

_____ Assign required readings

_____ Familiarize self with all materials, especially the interview scenarios

_____ Review articles on conducting and facilitating role plays

_____ Assess current interviewing skills of participants

TITLE

ASSESSMENT AND EVALUATION OF ADOLESCENT SUBSTANCE ABUSE

FORMAT(S)

Lecture
Case Discussion

SESSION GUIDELINES

Time:	2 hours
Prerequisites:	Sessions I (recommended), Sessions II and III (suggested)
Space Recommendations:	None
Suggested Number of Participants:	10 - 30

OBJECTIVES

After participating in this session, participants will be able to:

- identify several currently available screening approaches and describe their potential application in a pediatric setting
- identify patient, family and physician factors which aid or interfere with substance abuse recognition
- identify common signs and symptoms suggestive of substance abuse
- describe behavior patterns which would likely be exhibited by an adolescent harmfully involved with alcohol or other drugs
- utilize one's knowledge of age appropriate behavior and development to identify early warning signs of substance use/misuse

RELATED CURRICULUM GOAL(S)

I. To increase awareness of general concepts of substance abuse.

III. To increase recognition and diagnosis of substance abuse and its related sequelae.

IV. To provide the basic skills to effectively intervene and engage the patient and family into treatment.

V. To promote awareness of the pediatrician's role in prevention.

SYNOPSIS

This session uses a case to open discussion around the issues of assessment and evaluation. After the case discussion, a presentation of data is provided which contains information necessary for understanding the basic knowledge and skills around assessment and evaluation.

INSTRUCTOR'S RESOURCES

Anglin TM. Interviewing guidelines for the clinical evaluation of adolescent substance abuse. Ped Clinics of N Amer 1987; 34:381-398.

Blum RW. Adolescent substance abuse: Diagnostic and treatment issues. Ped Clinics of N Amer 1987; 34:523-538.

Farrow JA, Deisher RA. Practical guide to the office assessment of adolescent substance abuse. Pediatric Annals 1986, 15:675.

Niven RG. Adolescent drug abuse. Hospital and Community Psychiatry 1986; 37:596.

Semlitz L, Gold MS. Adolescent drug abuse: Diagnosis, treatment, and prevention. Psych Clinics of N Amer 1986; 9:455

Silber TJ. Adolescent marijuana use: The role of the physician. Adolescence 1987; 22:363.

Singer MI, Petchers MK, Anglin TM. Detection of adolescent substance abuse in a pediatric outpatient department: A double blind study. J of Pediatrics 1987; 111:938.

Verebey K, Martin DM, Gold MS. Interpretation of drug abuse testing: Strengths and limitations of current methodology. Psych Med 1987; 3:287.

SESSION OUTLINE

Introduction	TT: 5 MIN	RT: 5 MIN

Introduction of Presenter(s) and Participants

Review Purpose and Goals of Session [Handout 1]

Establish Ground Rules for Session

Review Materials

Case Presentation	TT: 10 MIN	RT: 15 MIN

Read case aloud with participants [Handout 7]

Focus on key teaching points using IM 1

Lecture and Group Discussion	TT: 35 MIN	RT: 50 MIN

A. Definitions

1. Use
2. Misuse
3. Abuse
4. Dependence

B. Progressive Stages of Substance Use/Dependence

1. Developmental issues/delayed development
2. Identification of signs and symptoms [Handout 4]
3. Use of AAIS as conceptual framework [Handout 5]

C. Dealing with Denial: How it Colors Information given by Patient/Family [Handout 6]

Evaluation (Optional)	TT: 5 MIN	RT: 55 MIN

Distribute evaluations and ask participants to complete [Handout 8]

Summary and Closure	TT: 5 MIN	RT: 60 MIN

Refer back to objectives to determine if they were successfully completed. Summarize session with group. [Handout 1]

INSTRUCTOR'S MATERIALS

Instructor's Material 1 - Case Illustration

Instructor's Material 2 - Focus Points for Case Discussion

All Learner Materials also serve as Instructor's Materials:

Handout 1-Session Objectives

Handout 2-Session Outline

Handout 3-Example of Adolescent Drug Use Statistics (Prevalence and Recency of Use)

Handout 4-Adolscent Substance Abuse Progression

Handout 5-Adolescent Alcohol Involvement Scale

Handout 6-Definitions of Denial

Handout 7-Case Illustration

Handout 8-Session Evaluation

Handout 9-Reference List

Handout 10-Anglin TM. Interviewing guidelines for the clinical evaluation of adolescent substance abuse. Ped Clinics of N Amer 1987; 34:381-398.

Handout 11-Hoffman NG, Harrison PA. Many facets of treating chemically dependent adolescents. Professional Counselor 1988; Jan:59-60.

Handout 12-Semlitz L, Gold MS. Adolescent drug abuse: Diagnosis, treatment, and prevention. Psych Clinics of N Amer 1986; 9(3):455-473.

PURPOSE: This case is to be used as the starting point for this session.

DIRECTIONS: Present the case to the group and then focus discussion around the several points noted in Instructor's Material 2.

CASE ILLUSTRATION

Greg is a 14 year old male who has been your patient for several years and comes today with his mother for a physical prior to basketball season. He has lost weight and complains of fatigue and discomfort from a recent shoulder injury. He says that the shoulder injury occurred during a conflict with his mother's boyfriend. Greg's medical history has been unremarkable and his emotional development seemingly advanced—as he has helped his mother take care of his younger siblings since the death of his father 5 years ago outside a neighborhood bar. Greg began drinking at age 13.

The physical examination shows him to be a well developed, well nourished male of normal height and weight and with no abnormal findings. As you begin to inquire about his fatigue and eating habits, Greg is interrupted by his mother who answers questions directed to him. She states, "He is just so careless and irresponsible—fighting with Jim (mother's boyfriend), staying up in his room all the time and he's been suspended twice from school for leaving during the day. He sure wasn't raised that way! It's all his new friends who he thinks are so wonderful...!" With this Greg jumps up and leaves your office and does not respond to his mother calling after him. His mother tells you this happens almost daily and that she thinks he's been using drugs with his friends. She insists that you test his urine.

FOCUS POINTS FOR CASE DISCUSSION

QUESTION	PURPOSE
1. What do you think of this situation?	To begin discussion among participants
2. What could be gained by testing Greg's urine?	To elicit benefits of urine screening (i.e., providing concrete data)
3. What about confidentiality?	To focus discussion on legal and ethical issues
4. Do you have enough data to make a diagnosis of substance abuse for Greg?	To focus discussion on how to make a diagnosis
5. What would you need to make a diagnosis?	To move discussion beginning of content outline (differences between use, abuse, and dependence)

Handout 1

ASSESSMENT AND EVALUATION OF ADOLESCENT SUBSTANCE ABUSE

SESSION OBJECTIVES

As a result of this presentation, participants will be able to:

- identify several currently available screening approaches and describe their potential application in a pediatric setting
- identify patient, family and physician factors which aid or interfere with substance abuse recognition
- identify common signs and symptoms suggestive of substance abuse
- describe behavior patterns which would likely be exhibited by an adolescent harmfully involved with alcohol or other drugs
- utilize one's knowledge of age appropriate behavior and development to identify early warning signs of substance use/misuse

ASSESSMENT AND EVALUATION OF ADOLESCENT SUBSTANCE ABUSE

SESSION OUTLINE

A. Case Discussion

B. Definitions

1. Use
2. Misuse
3. Abuse
4. Dependence

C. Progressive Stages of Substance Use/Dependence

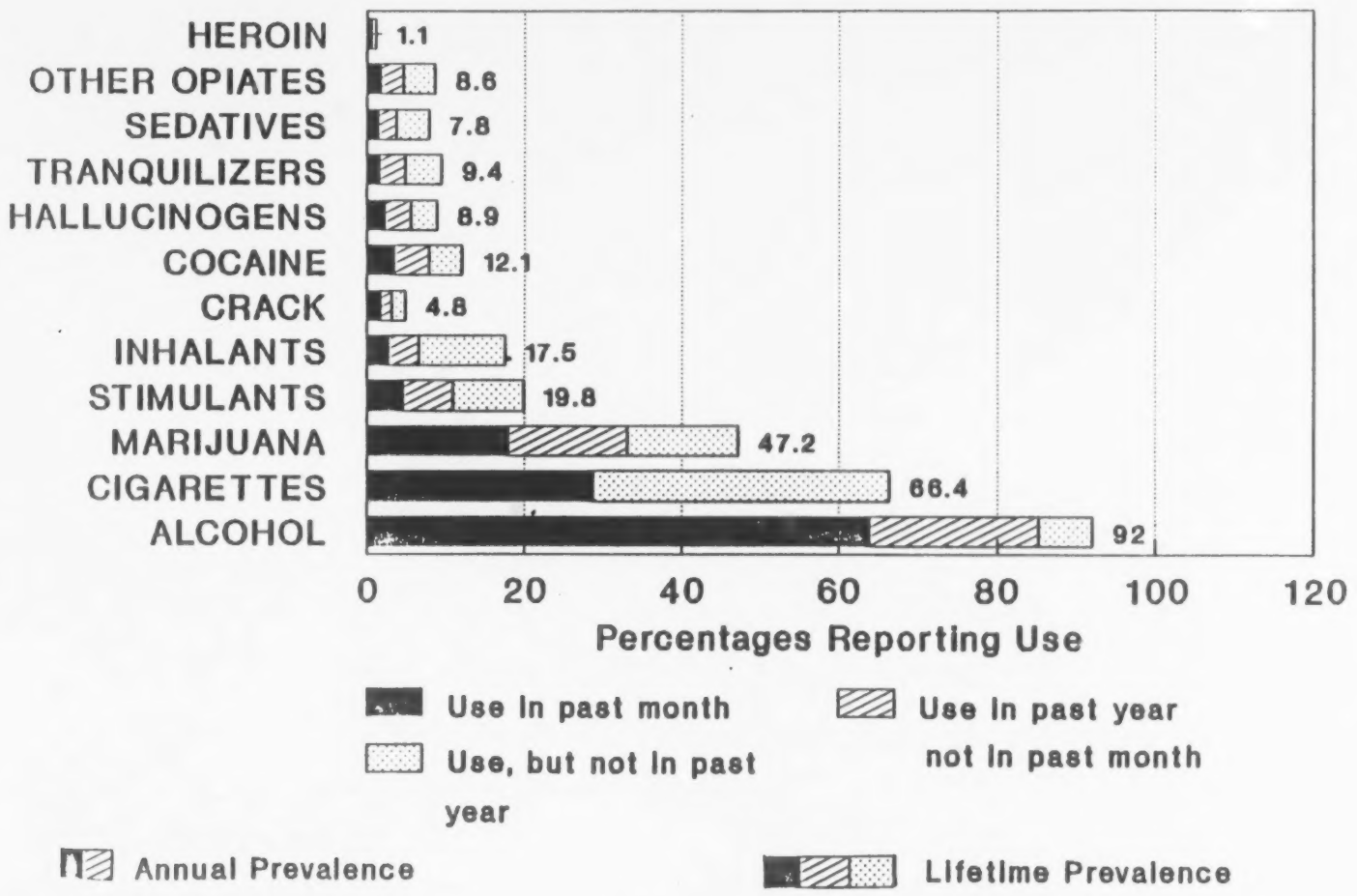
1. Developmental issues/delayed development
2. Identification of signs and symptoms
3. Use of AAIS as conceptual framework

D. Dealing with Denial: How it Colors Information given by Patient/Family

Handout 3

EXAMPLE OF ADOLESCENT DRUG USE STATISTIC

Prevalence and Recency of Use
Eleven Types of Drugs, Class of 1988



V
IV - 12

ADOLESCENT SUBSTANCE ABUSE PROGRESSION

STAGE 1: EXPERIMENTATION LEARNING THE MOOD SWING REACTION	PREDISPOSITION	BEHAVIOR	FAMILY
Infrequent use Alcohol/pot/inhalants No consequences Some fear of use Low tolerance	Curiosity Peer pressure Attempt to assume adult role	Learning the mood Feels good Positive reinforcement Can return to normal	Often unaware Denial
STAGE 2: SEEKING THE MOOD SWING			
Increasing frequency Use of various drugs Minimal defensiveness Tolerance	Impress others Social function Pride in amount consumed	Using to get high Use other than weekend Use to relieve feelings Denial of problem	Attempts at elimination Blaming others
STAGE 3: PREOCCUPATION WITH THE MOOD SWING			
Change in peer group Activities revolve around use Steady supply Possible dealing Few/no straight friends Consequences occur more frequently	Using to get loaded-not just high	Begins to violate values and rules Use before and during school Use despite consequence Solitary use Trouble with school Overdoses, "bad trips", blackouts Promises to cut down or attempts to quit Protection of supply, hides use from peers Deterioration in physical condition	Conspiracy of silence Confrontation Reorganization with or without affected individual
STAGE 4: USING TO FEEL NORMAL			
Continued use despite adverse outcomes Loss of control Inability to stop Compulsion	Use to feel normal	Daily use Failure to meet expectations Loss of control Paranoia Suicide gestures, self-hate Physical deterioration (poor eating and sleep habits)	Frustration Anger May give up

ADOLESCENT ALCOHOL INVOLVEMENT SCALE (AAIS)

1. How often do you drink?

(0) a. never
(2) b. once or twice a year
(3) c. once or twice a month
(4) d. every weekend
(5) e. several times a week
(6) f. every day

2. When did you have your last drink?

(0) a. never drank
(2) b. not for over a year
(3) c. between 6 months and one year
(4) d. several weeks ago
(5) e. last week
(6) f. yesterday
(7) g. today

3. I usually start to drink because:

(1) a. I like the taste
(2) b. to be like my friends
(3) c. to feel like an adult
(4) d. I feel nervous, tense, full of worries or problems
(5) e. I feel sad, lonely, sorry for myself

4. What do you drink?

(1) a. wine
(2) b. beer
(3) c. mixed drinks
(4) d. hard liquors
(5) e. have a substitute for alcohol, paint thinner, sterno, cough medicine, mouth wash, hair tonic, etc.

5. How do you get your drinks?

(1) a. supervised by parents or relatives
(2) b. from brother or sisters
(3) c. from home without parents knowledge
(4) d. from friends
(5) e. buy it with false identification

6. When did you take your first drink?

(0) a. never
(2) b. recently
(3) c. after age 15
(4) d. at ages 14 or 15
(5) e. between ages of 10-13
(6) f. before age 10

7. What time of the day do you usually drink?

(1) a. with meals
(2) b. at night
(3) c. afternoons
(4) d. mostly in the morning or when I first awake
(5) e. I often get up during my sleep and drink

8. Why did you take your first drink?

(1) a. curiosity
(2) b. parents or relatives offered
(3) c. friends encouraged you
(4) d. to feel more like an adult
(5) e. to get drunk or high

9. How much do you drink, when you drink?

(1) a. one drink
(2) b. two drinks
(3) c. 3-6 drinks
(4) d. 6 or more drinks
(5) e. until "high" or drunk

10. Who do you drink with?

(1) a. parents or relatives only
(2) b. with brothers or sisters only
(3) c. with friends own age
(4) d. with older friends
(5) e. alone

11. What is the greatest effect you have had from alcohol?

(1) a. loose easy feeling
(2) b. moderate "high"
(3) c. drunk
(4) d. became ill
(5) e. passed out
(6) f. was drinking heavily and the next day didn't remember what happened

12. What is the greatest effect drinking has had on your life?

(0) a. none-no effect
(2) b. has interfered with talking to someone
(3) c. has prevented me from having a good time
(4) d. has interfered with my school work
(5) e. have lost friends because of drinking
(6) f. has gotten me into trouble at home
(7) g. was in a fight or destroyed property
(8) h. has resulted in an accident, an injury, arrest, or being punished at school for drinking

13. How do you feel about your drinking?

(0) a. no problem at all
(2) b. I can control it and set limits on myself
(3) c. I can control myself, but my friends easily influence me
(4) d. I often feel bad about my drinking
(5) e. I need help to control myself
(6) f. I have had professional help to control my drinking

14. How do others see you?

(0) a. can't say or normal drinker for my age
(2) b. when I drink I tend to neglect my family or friends
(3) c. my family or friends advise me to control or cut down my drinking
(4) d. my family or friends tell me to get help for my drinking
(5) e. my family or friends have already gone for help for my drinking

SCORING

Scoring can range from 0 - 79:

0-19 = very little use

20-41 = use no problem

42-57 = alcohol misuser

≥ 58 = adolescent alcoholic

Mayer, JE and Filstead, WJ. The Adolescent Alcohol Involvement Scale: An instrument for measuring adolescents' use and misuse of alcohol. J Stud Alcohol 40: 291-300, 1977.

DEFINITIONS OF DENIAL

Denial is a defense mechanism which protects people from realities (losses, traumas, intense feelings) which are too painful. Denial comes in many subtle forms, all of which powerfully affect the chemically dependent family, interfere with long-term recovery, and promote relapse. Dealing with and overcoming denial begins with recognizing style(s) of denial. It is a process that continues throughout recovery.

Below are some of the many forms of denial that comprise people's denial systems—the ways in which they have avoided seeing, feeling, or believing the chemical dependency.

Minimizing - to shrink the amount of the drinking/drug use and/or the problems resulting from it

Narrow Focus - to single out and to look at only one situation or episode or problem

Separating - to consider the drinking/drug use as separate from and unrelated to problems and feelings

Compartmentalizing - to consider each drinking/drug use incident as unrelated to other drinking/drug use incidents

Rationalizing - to blame the drinking/drug use and/or the problems on someone or something else

Generalizing - to speak in vague general terms rather than specific details about your own experiences with the drinking/drug use, feelings, and problems

Reversing - to think that the problems cause the drinking/drug use and avoid discussions of intoxication/drugged behavior and problems which result from it

Defocusing - to distract the mind from the addiction by fixing attention on another problem, sometimes with very strong feelings about another problem

Repression - to block out the memory of unpleasant past experiences and confrontations about the problem

Projection - to block out your own problems and feelings by attributing those problems and feelings to others

Isolation of Affect - to relate experiences in a way that shows little or no feelings; sometimes to talk about very serious matters in a joking way

The Nevers - to avoid identifying what has happened as a result of drinking/drug use by focusing on what has not happened

Extreme Definitions - to avoid identifying the addiction by defining alcoholism and alcoholics/drug addiction and addicts in exaggerated ways

Uniqueness - to find ways to believe that your case is <u>different</u> - an exception to rules

Making Enemies - to make "<u>bad guys</u>" out of those who confront or try to help

Globalizing - to claim that <u>everybody</u> drinks, uses drugs, smokes, as you do

CASE ILLUSTRATION

Greg is a 14 year old male who has been your patient for several years and comes today with his mother for a physical prior to basketball season. He has lost weight and complains of fatigue and discomfort from a recent shoulder injury. He says that the shoulder injury occurred during a conflict with his mother's boyfriend. Greg's medical history has been unremarkable and his emotional development seemingly advanced—as he has helped his mother take care of his younger siblings since the death of his father 5 years ago outside a neighborhood bar. Greg began drinking at age 13.

The physical examination shows him to be a well developed, well nourished male of normal height and weight and with no abnormal findings. As you begin to inquire about the fatigue and Greg's eating habits, he is interrupted by his mother who answers questions directed toward him. She states, "He is just so careless and irresponsible—fighting with Jim (mother's boyfriend), staying up in his room all the time and he's been suspended twice from school for leaving during the day. He sure wasn't raised that way! It's all his new friends he thinks are so wonderful...!" With this Greg jumps up and leaves your office and does not respond to his mother calling after him. His mother tells you this happens almost daily and that she thinks he's been using drugs with his friends. She insists that you test his urine.

ASSESSMENT AND EVALUATION OF ADOLESCENT SUBSTANCE ABUSE
EVALUATION

1. Prior to the session, how would you have described your working knowledge of assessment and evaluation of a substance abuse problem?

1	2	3
Less Than Adequate	Adequate	More Than Adequate

2. As a result of the presentation, has your knowledge of assessment and evaluation improved?

1 No 2 Yes

3. Was the case study helpful in providing you with a conceptual framework for evaluating substance abuse problems?

1	2	3
Not Helpful	Moderately Helpful	Very Helpful

4. What was lacking from the presentation that would have helped clarify your thinking on this issue?

_____

_____

_____

5. What about this presentation was most helpful to you in improving your knowledge of alcohol and drug assessment and evaluation?

_____

_____

_____

6. What changes would you recommend for this presentation?

_____

_____

_____

THANK YOU

ASSESSMENT AND EVALUATION OF ADOLESCENT SUBSTANCE ABUSE
REFERENCE LIST

Anglin TM. Interviewing guidelines for the clinical evaluation of adolescent substance abuse. Ped Clinics of N Amer 1987; 34:381-398.

Blum RW. Adolescent substance abuse: Diagnostic and treatment issues. Ped Clinics of N Amer 1987; 34:523-538.

Farrow JA, Deisher RA. Practical guide to the office assessment of adolescent substance abuse.

Niven RG. Adolescent drug abuse. Hospital and Community Psychiatry 1986; 37:596.

Semlitz L, Gold MS. Adolescent drug abuse: Diagnosis, treatment, and prevention. Psych Clinics of N Amer 1986; 9:455

Silber TJ. Adolescent marijuana use: The role of the physician. Adolescence 1987; 22:363.

Singer MI, Petchers MK, Anglin TM. Detection of adolescent substance abuse in a pediatric outpatient department: A double blind study. J of Pediatrics 1987; 111: 938-...

Verebey K, Martin Dm, Gold MS. Interpretation of drug abuse testing: Strengths and limitations of current methodology. Psych Med 1987; 3:287.

EQUIPMENT

None required

SUGGESTED PREPARATION ACTIVITIES

_____ Assign required readings

_____ Advertise session if not a required class/course

_____ Familiarize self with all materials and resources

_____ Review articles on facilitating case discussion

_____ Develop student packets

_____ Assess needs, knowledge level, perceptions and related practice behaviors of participants

MODULE V: ADOLESCENT SUBSTANCE ABUSE TREATMENT

TITLE

ADOLESCENT SUBSTANCE ABUSE TREATMENT

FORMAT(S)

Lecture
Case Discussion
Group Discussion

SESSION GUIDELINES

Time:	1 Hour
Prerequisites:	Module I and IV Suggested
Space Recommendations:	None
Suggested Number of Participants:	15 - 40

OBJECTIVES

After participating in this session, participants will be able to:

- discuss the pediatrician's role in treatment
- identify family dynamics, individual roles and the impact of defensive resistance to treatment
- identify several treatment options and describe the basic philosophy
- identify the pediatrician's role in the development of a treatment plan for a patient

RELATED CURRICULUM GOAL(S)

I. To increase awareness of general concepts of substance abuse

IV. To provide basic skills to effectively intervene and engage the patient and family into treatment

SYNOPSIS

The purpose of this session is to provide participants with a familiarity of available treatment programs and resources. Often physicians are ambivalent about the effectiveness of treatment for substance abuse patients. A familiarity with treatment programs, personnel, and strategies may affect this.

INSTRUCTOR'S RESOURCES

Blum RW: Adolescent substance abuse: diagnostic and treatment issues. Ped Clinics of N Am 1987; 34: 523-537.

Bright GM, Hawley DL, Siegel PP: Ambulatory management of adolescent alcohol and drug abuse. Seminars in Adol Med 1985; 1: 279-292.

DuPont RL: Teenage drug use: opportunities for the pediatrician. J of Pediatrics 1983; 102: 1003-1007.

Friedman AS, Blickman NW: Program characteristics for successful treatment of adolescent drug abuse. J of Nervous and Mental Disease 1986; 174: 669-679.

MacDonald DI: Prevention of adolescent smoking and drug use. Ped Clinics of N Am 1986; 33: 995-1005.

MacKenzie RG, Cheng M, Haftel AJ: The clinical utility and evaluation of drug screening techniques. Ped Clinics of N Am 1987; 34: 423-436.

Niven RG: Adolescent drug abuse. Hospital and Community Psychiatry 1986; 37: 599-607.

Obermeier G, Henry P: Inpatient treatment of adolescent alcohol and polydrug abusers. Seminars in Adol Med 1985; 1: 293-301.

Schwartz R, Cohen PR, Bair GO: Identifying and coping with a drug-using adolescent: some guidelines for pediatricians and parents. Ped in Review 1985; 7: 133-139.

Semlitz L, Gold MS: Adolescent drug abuse: diagnosis, treatment, and

prevention. Psych Clinics of N Am 1986; 9: 455-73.

Wells LA: Chemical dependence among adolescents. Mayo Clinic Proceedings 1985; 60: 557-561.

Whitfield CL: Healing the child within. Health Communications, Deerfield Beach, FL, 1987.

Whitfield CL: A Gift to Myself (workbook to accompany Healing the Child Within) Health Communications, Deerfield Beach, FL, 1989.

Wheeler K, Malmquist J: Treatment approaches in adolescent chemical dependency. Ped Clinics of N Am 1987; 34: 437-447.

SESSION OUTLINE

Introduction	TT: 5 MIN	RT: 5 MIN

Introduction of Presenter(s) and Participants

Review Purpose and Goals of Session [Handout]

Establish Ground Rules for Session

Review Materials

Lecture	TT: 15 MIN	RT: 20 MIN

A. Dealing with Denial in Presenting the Diagnosis [Handout 3]

B. Range of Resources Available [Handout 4]

1. Evaluation
2. Therapy/Counseling
3. Education
4. Medical
5. Urinalysis
6. Interdisciplinary Team Approach

C. Range of Treatment Settings [Handout 5]

1. Self-Help Groups
2. Outpatient Intervention
3. Inpatient
4. Therapeutic Community

Case Presentation and Discussion	TT: 30 MIN	RT: 50 MIN

Read case aloud with participants [Handout 6]

Discuss case

Evaluation (Optional)	TT: 5 MIN	RT: 55 MIN

Distribute evaluations and ask participants to complete

Summary and Closure	TT: 5 MIN	RT: 60 MIN

Refer back to objectives to determine if they were successfully completed. Summarize session with group.

[Handout]

INSTRUCTOR'S MATERIALS

The Instructor's Materials are the same as the Learner's Materials:

Handout 1-Session Objectives

Handout 2-Session Outline

Handout 3-Definitions of Denial

Handout 4-[Example of Available Resources]

Handout 5-Range of Treatment Settings

Handout 6-Patient Case

Handout 7-Session Evaluation

Handout 8-References

SESSION OBJECTIVES

After participating in this session, participants will be able to:

- discuss the pediatrician's role in treatment
- identify family dynamics, individual roles and the impact of defensive resistance to treatment
- identify several treatment options and describe the basic philosophy
- identify the pediatrician's role in the development of a treatment plan for a patient

SESSION OUTLINE

A. Dealing with Denial in Presenting the Diagnosis

B. Range of Resources Available

1. Evaluation
2. Therapy/Counseling
3. Education
4. Medical
5. Urinalysis
6. Interdisciplinary Team Approach

C. Range of Treatment Settings

1. Self-Help Groups
2. Outpatient Intervention
3. Inpatient
4. Therapeutic Community

D. Case Presentation and Discussion

DEFINITIONS OF DENIAL

Denial is a defense mechanism which protects people from realities (losses, traumas, intense feelings) which are too painful. Denial comes in many subtle forms, all of which powerfully affect the chemically dependent family, interfere with long-term recovery, and promote relapse. Dealing with and overcoming denial begins with recognizing style(s) of denial. It is a process that continues throughout recovery.

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Definitions of Denial (cont.)

The Nevers - to avoid identifying what has happened as a result of drinking/drug use by focusing on what has not happened

Extreme Definitions - to avoid identifying the addiction by defining alcoholism and alcoholics/drug addiction and addicts in exaggerated ways

Uniqueness - to find ways to believe that your case is different, an exception to rules

Making Enemies - to make "bad guys" out of those who confront or try to help

Globalizing - to claim that everybody drinks, uses drugs, smokes, as you do

[Example of] Range of Available Rescurces

Evaluation

Therapy/Counseling

Education

Medical

Urinalysis

Interdisciplinary Team Approach

RANGE OF TREATMENT SETTINGS

A. Self-Help Groups
   1. Alcoholics Anonymous
   2. Narcotics Anonymous
   3. Chemical Dependency Anonymous
   4. AlAnon, Naranon, and Families Anonymous

B. Outpatient Intervention
   1. Intervention
   2. Evaluation
   3. Individual Therapy/Counseling
   4. Family Theraphy/Counseling
   5. Community Mental Health/Private Practice
   6. Abstinence Drug Free Programs
   7. Drug Treatment: Detoxification
   8. Urine Screening/Antabuse/Naltrexone

C. Inpatient
   1. Detoxification
   2. Therapy (28-60 days)
   3. Dual Diagnosis
   4. Psychiatry

D. Therapeutic Community (1-3 Years)
   1. Drug Free
   2. Group Orientation

PATIENT CASE
PROGRESSION OF CHEMICAL DEPENDENCY

The following is a rather typical case of drug dependency, a remarkably similar pattern in all but very rare cases. Mike is anybody who could have come from the ghetto, urban society, a small town, or from a suburban area. he could come from a family of any size, any means, any creed or religion, and any ethnic background. His value system, interests, philosophy and goals in life can be of any persuasion. The only specific requirements for Mike are that he be at least a little social minded and places some value on the opinion of his peers. He could come from a family that has a positive attitude about the drinking of alcohol and uses alcohol in responsible ways, from a family that accepts rather heavy abuse of alcohol, or a family that prohibits any use of alcohol. Mike may or may not have had some drinking experience within the family setting in childhood or early adolescence. In his early years, generally in the company of his closest friends, he surreptitiously experiments with alcohol use probably from some parental or illegally acquired supply. Under the cover of darkness, in somebody's car, or behind the school, he drinks with considerable curiosity and significant excitement. The majority of the group approve of this behavior and promote it persuasively. The drinking is done in an atmosphere of mutual trust and friendship. For Mike, the experience of intoxication the first time is exciting, adventurous, stimulating, joyful, and probably even hilarious. The remarkable feeling of well-being that Mike experienced exceeds or at least equals any personal experience he has had to that time. Even though he may later become ill in some manner or experience a hangover, these side effects seem incidental to what seemed to be a very enriching experience in getting "high". In our society Mike has no reason not to repeat the experience as often as is possible for him at that time. At some level of his being he makes a commitment to incorporate the experience of intoxication with alcohol into his life style—weekend dances or activities, stag parties, beach parties, and celebrations of any kind. It is this acceptance of intoxication as simply another dimension of living and this commitment to enjoying the state of intoxication in terms of the future that marks the onset of psychological dependence on getting high. Simultaneously Mike withdraws frequently from his family and old friends which may be ascribed to "teenage behavior", a stage that includes mood swings, defiance and a fierce commitment to independence from other's expectations. At times Mikes family notices these changes but it seems he is less and less often around and doesn't ask for much-including money-even though he has not kept his part time job. It is easier to understand drug dependency of this initial commitment to the positive pleasure and the adaptive reaction of family is understood.

It is at this point in Mike's life that he repeats the experience of getting high whenever it is convenient to drink "socially." Within the next six months to two years Mike will have repeated the experience of getting high sufficiently often so that he develops an irreversible psychological need to repeat the experience. In today's society and in the youth drug culture it is an easy step for Mike to use other substances to experience other kinds of intoxication with whatever is agreeable to his system. Intoxication is the "hooker" in drug dependency and whichever drug accomplishes this becomes part of the drug dependency game of intoxication.

PATIENT CASE (CONT.)

As time goes by, Mike inevitably encounters some infinite variety of complications as a result of his drug dependency. They may be physical, social, legal, relationship or family problems. At this point he starts to use the experience of intoxication as a refuge or an escape from the tensions these problems or complications cause. The use of his intoxicants as a refuge or problem solving technique, to fight the growing panic on the way, serves to strongly reinforce the primary psychological dependence. So what we have at this time in Mike's life is dependency based on positive reinforcement for pleasure and a secondary psychic dependence on the drug experience rooted in the desire to avoid pain. It is a compulsive cycle that repeats itself, often against conscious will. The trap is now complete and Mike is profoundly hooked. The complications he will recurrently encounter are of a increasing and progressive nature and vary individually, according to the circumstances of his particular ongoing life. Mike develops an elaborate physiological defense to protect himself from the knowledge that he has been rendered helplessly and profoundly dependent on the drug experience.

Repression, rationalization, projection and denial are the defense mechanisms used predominantly. Typically these are so successful in accomplishing their purpose so that Mike is the last to realize his dilemma. In addition, getting "high" becomes more and more a "people substitute" and Mike experiences recurrent depression, anxiety, and sometimes despair at his feelings of alienation and loneliness. He may at times feel suicidal or "insane." Mike loses his ability to communicate with "important" others meaningfully, especially those who do not join into his drug induced reality, and he remains in a suspended state of growth. Rendered unstable, Mike's immature feelings and methods of relating emerge and dominate his total personality. It is painful to be with Mike because he exhausts people with his egocentricity. Mike's need for interpersonal intimacies go unmet and without help the progressive cycle of drug dependency continues. At this point there are only three outcomes possible: insanity, death, or recovery.

EVALUATION FORM

1.	How would you describe your knowledge of substance abuse treatment modalities:	less than adequate	adequate	more than adequate
	a. prior to the session?	1	2	3
	b. after the session?	1	2	3
2.	How helpful was the case study in each of the following:	not very helpful	helpful	very helpful
	a. illustrating the progressive nature of addiction?	1	2	3
	b. providing discussion points around the role of the physician?	1	2	3
3.	How likely is it that you would refer a patient to treatment in the following circumstances:	very unlikely	likely	very likely
	a. if a parent requested such for his/her adolescent who you thought was chemically dependent?	1	2	3
	b. for a chemically dependent adolescent whose parent(s) are ambivalent or even unaware of a problem?	1	2	3
	c. for a patient's parent who you knew had a chemical dependency?	1	2	3

4. What was most helpful to you in today's presentation?

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5. What was least helpful or what changes would you recommend?

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THANK YOU

REFERENCES
ADOLESCENT SUBSTANCE ABUSE TREATMENT

Blum RW: Adolescent substance abuse: diagnostic and treatment issues. Ped Clinics of N Am 1987; 34: 523-537.

DuPont RL: Teenage drug use: opportunities for the pediatrician. J of Pediatrics 1983; 102: 1003-1007.

Friedman AS, Blickman NW: Program characteristics for successful treatment of adolescent drug abuse. J of Nervous and Mental Disease 1986; 174: 669-679.

MacDonald DI: Prevention of adolescent smoking and drug use. Ped Clinics of N Am 1986; 33: 995-1005.

MacKenzie RG, Cheng M, Haftel AJ: The clinical utility and evaluation of drug screening techniques. Ped Clinics of N Am 1987; 34: 423-436.

Niven RG: Adolescent drug abuse. Hospital and Community Psychiatry 1986; 37: 599-607.

Semlitz L, Gold MS: Adolescent drug abuse: diagnosis, treatment, and prevention. Psych Clinics of N Am 1986; 9: 455-73.

Wells LA: Chemical dependence among adolescents. Mayo Clinic Proceedings 1985; 60: 557-561.

EQUIPMENT

None required

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SUGGESTED PREPARATION ACTIVITIES

_____ Assign required readings

_____ Familiarize self with all materials

_____ Review articles on conducting and facilitating case discussions

_____ Develop student packets

_____ Familiarize self with needs of participants